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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

HALIFAX

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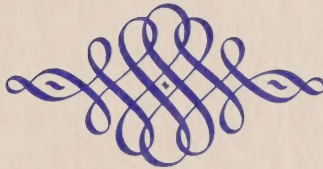
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Briefs 2 - 7



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I N D E X

Page No.

ROYAL COMMISSION ON HEALTH

HON. R. L. STANFIELD

The Government of Nova Scotia

Witnesses and to signatories

Witnesses, called to the

Witnesses, called to the

City of Halifax

Brief

Evidence

Dalhousie University

COMMISSIONERS

Brief

Witnesses, called to the

Provincial Medical Board

Mr. DAVID M. DAVIS

Brief

Evidence

Prof. J. G. JORDAN

Canadian Medical Association

C. G. MONTGOMERY

Filing of Exhibit No. 6.

(Future requirements for Physicians

in Canada)

Dr. ARTHUR W. R. RUTHVEN

Medical Society of Nova Scotia

COMMISSIONERS

Brief

Evidence (Concluded in Vol. 4)

Mr. C. G. J. HALL, M.R.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

VOLUME 3

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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held at Halifax, Monday,
October 30th, 1961

COMMISSION MEMBERS:

Chief Justice EMMETT H. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Mr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE



PROCEEDINGS OF THE HEARING

Proceedings of the hearing
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October 21, 1941

Chief Justice EMMETT H. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Mr. DAVID M. BALTAN

Prof. O.J. FIRESTONE

Dr. G.L. STRACHAN

Dr. ARTHUR F. VAN WART



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

237

Halifax, Nova Scotia,
Monday, October 30th,
1961.

1

2 ---- On commencing at 10 a.m.

3

4 THE CHAIRMAN: Mr. Premier, Mr. Donahoe,
5 ladies and gentlemen, we are now about to start the public
6 hearings in connection with this Commission and we are very
7 happy to be in Halifax and to start our program of public
8 hearings in this City and Province. For me it is a great
9 pleasure to come to Halifax for the first time and I am
10 looking forward to enjoying my stay here.

11

12 Mr. Premier, I understand you wish to make a
13 statement.

14

15 HON. R.L. STANFIELD: Mr. Chairman and
16 Commissioners, I would just like to say a word of welcome
17 to you to our Province and say how pleased we are that
18 you are commencing your hearings here in this historic
19 Red Chamber in this legislative building.

20

21 The Government of this Province welcomes the
22 appointment of this Commission. I believe that a good deal
23 of information was compiled by the Rowell-Sirois Commission
24 before the war, but I would expect that a very different
25 set of circumstances prevails today. Since that time the
26 Government of Canada has accepted a considerable degree of
27 responsibility in the field of health services, making
28 federal grants in various connections and to various
29 services bearing a substantial proportion of the cost of
30 the hospital plan. We would expect that the findings of
your Commission, my lord, would be of great significance
for all Canadians. We are only too happy here to co-operate
in any way that we can and, as I say, we are delighted to
have you here, and it is a privilege for me to be able to

THE CHAIRMAN: Mr. Premier, Mr. Donahoe,

ladies and gentlemen, we are now about to start the public hearings in connection with this Commission and we are very happy to be in Halifax and to start our program of public hearings in this City and Province. For me it is a great pleasure to come to Halifax for the first time and I am looking forward to enjoying my stay here.

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federal grants in various connections and to various services bearing a substantial proportion of the cost of your Commission, my lord, would be of great significance for all Canadians. We are only too happy here to co-operate

have you here, and it is a privilege for me to be able to



1 welcome you, Mr. Chairman and your Commissioners, as distin-
2 guished Canadians. It is an honour to have you visit our
3 Province and I would like to take this opportunity on
4 behalf of the Government and the people of Nova Scotia to
5 bid you welcome and to wish you well.

6 THE CHAIRMAN: Thank you very much, Mr.
7 Premier. I think I might say on behalf of my fellow
8 Commissioners and those with whom we are associated that
9 your presence here this morning is a very good thing, and
10 we regard it as an indication of the very profound interest
11 which the Government and the people of Nova Scotia have in
12 this subject. We are finding that the public of Canada is
13 very much interested in the subject that we have been asked
14 to look into, and your leadership in being here, in offering
15 the co-operation of your Government, and in the preparation
16 of the brief which is being given by the Government of Nova
17 Scotia augurs well for the co-operation that we are getting
18 in Nova Scotia and which we have every reason to believe
19 we will get throughout the rest of Canada. Thank you very
20 much, Mr. Premier.

21 Our very efficient Secretary, Mr. Lafrance,
22 has prepared an agenda, and the first item is the presenta-
23 tion of the submission on behalf of the Government of Nova
24 Scotia.

25 The Honorable Mr. Donahoe, Minister of Health.

26 SUBMISSION OF THE GOVERNMENT OF NOVA SCOTIA

27 Appearance: The Hon. R.A. Donahoe - Minister
28 of Health

29 HON. MR. DONAHOE: Your lordship Mr. Chairman,
30 madam and members of the Commission, may I begin by adding



behalf of the Government and the people of Nova Scotia to
bid you welcome and to wish you well.

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SUBMISSION OF THE GOVERNMENT OF NOVA SCOTIA

Appearance: The Hon. R.A. Donahoe - Minister
of Health



1 my personal word of welcome to this Commission and that of
2 the Department of Health of the Province of Nova Scotia.
3 I and the Department were delighted indeed to find the
4 Government of Canada was sufficiently interested and con-
5 cerned with the matter of health services that it could
6 appoint the Commission which you madam and you gentlemen
7 form, and consequently we were very happy indeed to see
8 the Commission appointed and to be advised it was to
9 commence its public hearings in this historic Province of
10 Nova Scotia. I may say this was one occasion when the
11 honour of being first was perhaps not as fully appreciated
12 as it may be on some other occasions because it put us in
13 the position where we were expected to come forward with
14 views and opinions and information for your benefit which
15 had to be compiled and amassed in a space of time which
16 was, in our opinion, at least, far too short for the work
17 required. Therefore, I want to say at the very outset that
18 the submission we make here this morning is in the nature
19 of a preliminary submission. It is not intended to be
20 definitive or conclusive in any way at all. It is merely
21 an effort on our part at this time to apprise you of the
22 circumstances and facts respecting the provision of health
23 services in the Province, and I cannot emphasize that too
24 strongly, that you ought not to expect from us this morning
25 and will not receive from us anything in the way of defi-
26 nite recommendations as to what you should do. What we
27 are attempting to do for you this morning is to present the
28 problem that is the prerogative of your Commission to inves-
29 tigate in a way that will give you the background of the
30 situation in this Province and, as I have already arranged

1 my personal word of welcome to this Commission and that of
 2 the Department of Health of the Province of Nova Scotia.
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 4 Government of Canada was sufficiently interested and con-
 5 cerned with the matter of health services that it could
 6 appoint the Commission which you madam and you gentlemen
 7 form, and consequently we were very happy indeed to see
 8 the Commission established and we are confident it will
 9 be a success. I am sure that the Commission will be able to
 10 do its work in a most efficient manner and I am sure that
 11 the position where we were expected to come forward with
 12 views and opinions and information for your benefit which
 13 had to be compiled and amassed in a space of time which
 14 was, in our opinion, at least, far too short for the work
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 19 a submission of facts and figures and information for your
 20 consideration and facts respecting the provision of health
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1 with you, Mr. Chairman, we reserve the right, if that is
2 the way to put it -- at least, you have given us the
3 privilege (it would be more graceful to say) of submitting
4 a further brief on a later occasion. This is to be agreed
5 between us: whether it be done by merely a submission of a
6 written brief at an appropriate time, or whether it should
7 be reserved until you have your final roundup of hearings,
8 if I may call them that, in Ottawa, is something that is
9 still to be settled, but it is clear, I think, it is our
10 hope and proposal to come forward with more definite and
11 further statements at some later date.

12 THE CHAIRMAN: Mr. Donahoe, perhaps I might
13 say, in relation to having chosen Nova Scotia, we heard
14 you were the best-natured people in Canada.

15 HON. MR. DONAHOE: Sometimes your reputation
16 can get you into difficulty, my lord.

17 THE CHAIRMAN: I say that with some experience
18 because quite a few years ago I had the good judgment to
19 marry a girl who was born in Nova Scotia.

20 HON. MR. DONAHOE: I must say I cannot think
21 of anything your lordship could say that would make you
22 more welcome here. We thought you were very welcome indeed,
23 but now that we know that about you we will increase the
24 heartiness of our welcome.

25 I think it should be said before commencing
26 the presentation that the observations which I am about
27 to make are observations on this brief which has been
28 prepared, and copies of which have been distributed to you,
29 and I have no desire and no intention, and I am sure you
30 would not let me go through this brief in detail at this



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1 time. However, I want to make it clear these observations
2 are based on information which we believe to be accurate
3 and reliable which we have gathered together as quickly as
4 was possible, but it should not be understood that they in
5 any sense represent exhaustive studies or are the result
6 of exhaustive studies. We tapped the various sources
7 available to us in an effort to get as much information as
8 possible and get it together in a readable and understand-
9 dable form in a short space of time, but we do not by any
10 means pretend to have exhausted any of these subjects or
11 to have done more than get what information we could in
12 the time which was available to us, and I had the privilege
13 of attending the opening session of your Royal Commission
14 hearings in Ottawa, and at that time you gave an under-
15 taking on behalf of the members of the Commission which I
16 welcome, and it was that if those presenting briefs would
17 not endeavour to go into the fullest of detail in the
18 presentation of them that we could rely upon the fact that
19 you and all members of your Commission would peruse every
20 word presented to you. That, I think, is a very fine
21 position to take and one on which we will rely. I am sure
22 it will have -- at least, I hope it will have -- the effect
23 of shortening the proceedings so that you will be able to
24 hear all those anxious to be heard in the time which you
25 are able to allot for that purpose.

26 A very casual perusal of the material
27 contained in this brief will indicate the wide range of
28 health services available in varying degree to the citizens
29 of this Province, and it will also soon become clear that
30 the major element in these services is medical care, and

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1 that when you discuss medical care the major component of
2 medical care is the rendering of services by physicians
3 and closely associated are the nursing and ancillary medical
4 services which are necessary to make a medical care program
5 operate successfully.

6 The provision of hospital facilities and
7 coverage is, of course, also a major component, since much
8 of the medical care given is in hospital.

9 At this time in Part I of this brief only
10 the various aspects of the present health services program
11 will be dealt with.

12 Part 2 of this brief, to be submitted at a
13 later date, will deal more specifically with planning and
14 requirements for the future.

15 I think it would be appropriate for me to
16 make certain observations based on the subject matter of
17 the brief, and I do so herewith.

18 There are too few students interested in the
19 practice of medicine in the Province of Nova Scotia: put a
20 little more accurately -- too few are entering the medical
21 schools. We believe that what is required is an improve-
22 ment in recruitment, and that in order to achieve that
23 improvement it may be necessary for you to consider propo-
24 sals respecting some method of financial assistance to
25 medical students. We believe that facilities for training
26 doctors in this Province are perhaps not sufficient to
27 provide the number of doctors that it would be desirable
28 for us to have, and that the ability of the medical school
29 at Dalhousie University to graduate sufficient physicians
30 for the Atlantic Provinces, and in particular, of course,



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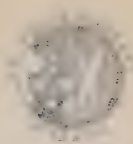
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1 for this Province, is due to space and other limitations
2 deserving of some re-examination with a view to ascertaining
3 its adequacy. We come to this conclusion, that there is
4 an insufficient number of physicians and specialists prac-
5 tising in Nova Scotia according to Canadian standards: our
6 Province has doctors in a proportion to one thousand of
7 population which is not very favourable to us. We have,
8 I am informed, one doctor for each 1,013 people. We are
9 better in this respect than New Brunswick but we are consi-
10 derably worse than in Manitoba which has one doctor for
11 each 879 people, and I have here the average figure for all
12 of Canada which is 879. So, Manitoba has exactly the
13 Canadian average of doctors per thousand of population,
14 while we are substantially worse off in that regard.

15 Moreover, the medical personnel that are
16 available to us in this Province are not distributed
17 equally throughout the Province. There is a tendency, as
18 will appear, and I may say again later, for specialists
19 to concentrate in certain areas. There is a tendency for
20 the medical profession to establish itself near the larger
21 and more popular centres, and this results in an unequal
22 distribution of such personnel, and it has to be admitted
23 that in this Province, as a result of that, certain areas,
24 particularly the more remote rural areas are not adequately
25 served with the availability of medical service.

26 We find also on examination that despite
27 major advances in the field -- and we have trained 502
28 persons under health grants since 1948, there is a definite
29 shortage in the Province of ancillary medical personnel
30 such as laboratory technicians, physio and occupational



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25 served with the availability of medical service.
26 We find also on examination that despite
27 major advances in the field -- and we have trained 502
28 persons under health grants since 1948, there is a definite
29 shortage in the Province of auxiliary medical personnel
30 such as laboratory technicians, physio and occupational



1 therapists, medical-social workers, medical record libra-
2 rians and others in the associated lines of work. If any
3 new scheme of medical care is to be successful, there must
4 be more emphasis on this part of the program. You will
5 find more complete and fuller reference to this problem
6 at pages 20 and 21 of the brief.

7 Mr. Chairman. During the period 1956 to 1961 inclusive we
8 have added to our capacity in this Province 644 hospital
9 beds; that is, general hospital beds, and we are planning
10 to have an additional 87 beds in the year 1962. Plans
11 have been approved in principle for a further 912 beds to
12 be completed after 1962. Further and more detailed infor-
13 mation respecting this aspect of our program is to be
14 found at pages 27 to 30.

15 Despite this increase there will be still be
16 some areas of the Province with insufficient hospital beds
17 and facilities based on Canadian standards, but that will
18 be relatively small because in general, with the addition
19 of the numbers of beds of which I have spoken, we will
20 have achieved the goal of 5.5 beds per one thousand of
21 population on the average across the Province, which I am
22 informed serves the need reasonably insofar as general
23 hospital beds are concerned.

24 It is understood and we do believe that there
25 are some long-term and convalescent beds that will be
26 required in addition, and that in line with experience
27 gained after 2 years of a hospital care program careful
28 study should be given to the need for convalescent and
29 chronic hospital beds as part of a hospital care scheme.

30 We believe also that much attention should be



1 new scheme of medical care is to be successful, there must
2 be more emphasis on this part of the program. You will
3 find more complete and fuller reference to this problem
4 at pages 20 and 21 of the brief.

5 During the period 1956 to 1961 inclusive we
6 have been working on the problem of hospital beds
7 and the results are as follows: (a) The number of
8 hospital beds has increased from 100,000 in 1956 to
9 150,000 in 1961. (b) The number of hospital beds
10 per 1,000 population has increased from 0.5 in 1956 to
11 0.75 in 1961. (c) The number of hospital beds
12 per 1,000 population has increased from 0.5 in 1956 to
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15 some areas of the Province with insufficient hospital beds
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30



1 paid to the question of developing nursing home care and
2 Home Care (Domiciliary) programs with the possibility of
3 integrating such programs with the Hospital Care Program.
4 You will find reference to that in paragraphs 97 to 101 and
5 paragraphs 102 to 110.

6 With reference to that aspect of the matter,
7 Mr. Chairman, I might say that this Province, though it is
8 relatively short of hospital beds, on the 1st of January
9 1959, when the hospital insurance plan was inaugurated in
10 the Province, by exercise of great care and a certain
11 measure of forbearance on the part of the public to be
12 served, we have managed to provide hospital care for all
13 those persons requiring it. Some didn't receive it as
14 expeditiously as they would like to have received it, but
15 we have managed to care for all emergency cases and,
16 within limits, for all those requiring active hospital
17 treatment, and we have been making strenuous efforts
18 towards the provision of additional facilities towards that
19 end. These are coming, and are to be found now in various
20 parts of the Province.

21 I have just returned to the City from a
22 week's absence at another conference, and on my return I
23 found before me plans for submission to the Hospital
24 Insurance Commission for the extension and almost the
25 renewal of the facilities at the Victoria General Hospital,
26 which is our provincial medical centre and teaching insti-
27 tution and referral hospital for the Province of Nova Scotia.
28 The reason I deal with that situation is that because we
29 were inadequately supplied with beds there has been a very
30 great strain and a very great demand upon our resources to



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tution and referral hospital for the Province of Nova Scotia

The reason I deal with that situation is that because we



1 provide this need, and the Province has felt it necessary
2 to try to encourage the building of hospital beds by the
3 making of grants 50% greater than the grants available
4 from the Federal Government. In other words, the Federal
5 Government is giving a grant of \$2,000 a bed, and we felt
6 it necessary -- and we were required under the arrangements
7 to match that grant -- but we felt in addition that should
8 be increased by an additional \$1,000 per bed, making a
9 grand total of \$5,000 a bed. This grant, while it has
10 still left a very considerable burden upon the local autho-
11 rities responsible for the provision of hospital care in
12 this Province, because we have not assumed control of the
13 hospitals; we do provide under the Hospital Insurance Plan
14 for payment of the operating expenses, and there is some
15 modest provision for providing that -- but we do, apart
16 from the grant provided for the actual capital required
17 to provide for the hospital facilities in the first instance.
18 The 5,000 for the bed -- 2,000 from the Federal Government
19 and 3,000 from ourselves -- has stimulated an interest in
20 hospital construction, and we have already a number of new
21 ones erected, and in the next few years we figure we will
22 get up to standard.

23 Our problem is one very much, though, that
24 you might take note of, and it is that the federal contri-
25 bution is in a sense a limited contribution. It is \$2,000
26 a bed, but not for an unlimited number of beds. There is
27 a ceiling on the amount which the Federal Government is
28 prepared to provide in the way of construction grants for
29 hospitals, and while that ceiling may have been adequate
30 in some other Provinces, in our Province, because of the



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1 fact we started with too many too few beds, it left us in
2 the position where we now feel we have before us proposals
3 for the construction of additional beds and other facilities
4 such as nurses' residences.



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1 First of all, these proposals before us are
2 adequate, they are necessary, they can be approved, but if
3 all that are before us at the moment should be approved
4 there will not be available sufficient money by way of
5 federal grants for us to carry out our complete program.
6 I would like you to know that we as a Government have
7 urged upon the Federal Government that it should, if at
8 all possible, make more money available for this purpose
9 in Nova Scotia in order that we may reach the standard
10 that we think it is desirable that there should be. The
11 lack of sufficient funds - and I want to stress the fact
12 that this lack will not be on the part of this Province;
13 with the greatest of difficulty we will continue to be
14 able to find our share of the construction grant, even
15 when we reach the point where we are operating on projects
16 where there is no federal money available. But I am sure
17 you will understand that our share alone will not be
18 sufficient to encourage people to go into the construction
19 of hospital beds unless they get the same measure of help
20 as those who are now receiving both provincial and federal
21 grants.

22 So in the matter of health services - the
23 provision of hospital care is an essential part of the
24 program - we are going to have difficulty in financing the
25 total number of beds in this Province unless we get in due
26 course of time federal money. I think it should be clear
27 that at the moment the Federal Government has provided
28 additional monies which are available over the period 1963
29 to 1968. We have plans that will commit all the Federal



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... course of time federal money. I think it should be clear
... that at the moment the Federal Government has provided



1 money up to 1968; and in addition to that many of those
2 plans will come into fruition before 1968, and the federal
3 money is not available to us in one lump sum but in roughly
4 equal annual instalments. So we are going to find ourselves
5 in the position that we can not only use all the federal
6 money but we can use it for 1968. It may be that we will
7 have to wait a year or two or even three in some instances.
8 Perhaps I am exaggerating a little; perhaps we won't get
9 any construction program that far ahead that there will be
10 as long as a 3-year gap, but I think it is clear that in a
11 number of instances there will be a gap and we will have
12 used all the federal money before, first of all, all the
13 money is available, and, when it is fully available, it
14 isn't adequate for the needs of hospital construction in
15 this Province.

16 My fifth point is that there is a major
17 shortage of dental students and dental practitioners in
18 the Province, and I refer you for further information on
19 this to pages 46 to 50 of this brief.

20 That the situation must be regarded as
21 serious if not remedied, and this is of paramount impor-
22 tance to our citizens of all ages.

23 In this Province we have made some effort to
24 improve the standard of dental care for our people by pro-
25 viding mobile dental units, and I think there are three
26 such dental units which it has been the practice to send
27 out on circuit in summer in communities where there is no
28 dentist and there are long areas where a dentist cannot be
29 found. We were unable to do this last summer. We think
30 this is simply because it was impossible for us to find
dentists who were available to undertake the



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is simply because it was impossible for us to find

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1 operation of these mobile clinics. I think this points up
2 the problem we have in order to provide a high and proper
3 standard of dental care for the people of this Province.

4 Sixthly, that the requirements for trained
5 nursing personnel be carefully considered - present figures
6 would indicate a definite overall shortage in the Province,
7 and it is much more noticeable in some areas than in others.
8 In the academic field of nursing we find that there is an
9 alarming shortage of teaching personnel, and we have the
10 same problem in the Public Health Nursing field. On that
11 point I refer you to paragraphs 167 to 174 of this brief
12 and paragraphs 85 to 96.

13 Despite an extensive building program for
14 Nursing Residences and planned developments for the future
15 there appear to be further requirements for accommodation
16 as well as teaching facilities. Either an increased number
17 of Nursing Schools or major enlargement of present facilities
18 will be required, and I refer you to paragraph 159,
19 simply again to underline, I go back and say that in the
20 construction of these facilities we again rely very substantially
21 on the federal construction grants to build Nursing
22 Residences, and every observation I made with respect to
23 hospitals applies with equal force to Nursing Residences,
24 because the same fund and only that fund applies to Nursing
25 Residences; and I am including in this project not only the
26 active treatment hospital beds but the provision of nursing
27 teachers and nurses as well.

28 Generally speaking, what I have said is, to
29 somewhat a lesser degree, applicable to accommodation and
30 training schools for nursing assistants, and there should



operation of these mobile clinics. I think this points up
the problem we have in order to provide a high and proper
standard of dental care for the people of this Province.
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personnel in the dental field are such that there is an
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teachers and nurses as well.

Generally speaking, what I have said is to
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1 be continued studies for the best method of training
2 nurses. Your lordship will no doubt hear a great deal
3 more about that in the course of your studies, and while
4 the nurses will speak for themselves and have definite
5 views on how nursing teaching should proceed in this
6 country, I won't elaborate except to say that these propo-
7 sals deserve the highest and closest of scrutiny, because
8 it is very essential that we should be able to provide an
9 adequate number of nurses and any change in the system or
10 any improvement in the system which would provide a greater
11 output of trained nursing personnel is greatly to be
12 desired.

13 In this Province we have enlarged our Central
14 Laboratories, we have modernized them, we have established
15 a regional system of laboratories throughout the Province.
16 We have divided the Province into hospital regions, and in
17 each of these regions we are attempting to provide a hospi-
18 tal which will be equipped with diagnostic facilities on
19 a higher scale than has been known in this Province pre-
20 viously. We are unable to gauge at the moment exactly what
21 the effect of providing these facilities will be on the use
22 of our central facilities for use in Halifax, because there
23 are two schools of thought on this matter. There are
24 those who say that with the increase in regional facilities
25 there will be a greater number of referrals to Halifax, and
26 there are others who say that the improved diagnostic
27 facilities in the regions will enable more treatment to be
28 given and will cut down on the number of referrals.

29 For the first time in this Province we are
30 providing a system of regional hospitals, better equipped

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of regional hospitals, better equipped



1 and able to provide greater diagnostic services, and with
2 the problem of trained personnel, this means a very much
3 higher degree of service to our people than was possible
4 before this program was undertaken. On that note number
5 seven I refer you to paragraphs 139 to 147 of this brief.

6 Number eight: we believe that you will be
7 obligated in the course of your duties to make a close
8 examination and study of the drug situation. This must
9 be particularly with reference to drugs being supplied as
10 part of any medical care scheme. We have a submission with
11 respect to that on pages 44 and 45, some observations with
12 respect to what we believe the situation to be, and I
13 thought it may be just of interest if I briefly went over
14 what we are doing in that particular field. In all our
15 general hospitals under the plan all necessary drugs are
16 ordered and covered by the Hospital Insurance Plan without
17 cost to the patient. Biologicals for the prevention of
18 communicable diseases are available from the Department
19 of Public Health on a free basis, and the doctor who
20 receives these biologicals is obliged to administer them
21 either free or on a reduced charge basis. We also provide
22 such things as polio vaccine, smallpox vaccine, quadruple
23 antigen, and others. On a means test basis we provide
24 insulin, anti-diabetic drugs and test materials to those
25 suffering from diabetes mellitus. We provide penicillin
26 for the treatment of venereal disease, and we provide free
27 drugs for the treatment of tuberculosis, both in and out
28 of sanatoria. The Government provides tranquilizing drugs
29 for use in mental hospitals.

30 We simply say this: that one of the great

and with

a problem of trained personnel, this means a very much
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suffering from diabetes mellitus. We provide penicillin

and other drugs for the treatment of rheumatoid, gout and other



1 problems in providing health services is this very matter
2 of providing drugs and pharmaceuticals, and one to which
3 you are going to have to give close attention. The Govern-
4 ment programs are substantial in themselves but they do
5 not by any means pretend to cover the field. They are
6 only in the field where the need appears to be the
7 greatest, and there are many drugs available today and
8 many illnesses which are susceptible to the administration
9 of drugs where we believe it would be impossible for the
10 Government to undertake the distribution of these drugs.
11 I recall to mind the pitiful situation of people suffering
12 from cystic fibrosis. There are drugs available which give
13 them a certain amount of ease, but in the very nature of
14 this disease these drugs do not provide anything more than
15 relative comfort to the people afflicted with this disease,
16 and these are expensive medications. When one starts to
17 consider providing them from the public purse, it always
18 seems that the criterion ought to be if you can really, by
19 providing such a program, restore persons to health and
20 their ability to take their useful place in society, and
21 this appears to be the type of distribution which should
22 be given priority, nevertheless, it is most distressing
23 for persons who have members of their family afflicted
24 with some of these rare diseases, and these people must
25 have a great financial burden thrust upon them, and if
26 there is to be some program of assistance, one would
27 think it ought to be a program related to the persons who
28 are most heavily burdened financially to the requirements
29 of providing drugs and medications. In any event, you
30 cannot make a comprehensive study of health services

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26 there is to be some program of assistance, one would
27 think it ought to be a program related to the persons who
28 are most heavily burdened financially to the requirements
29 of providing drugs and medications. In any event, you



1 without including this very important matter of drugs, and
2 I would think you would find it one of the most contentious
3 presentations that you have before you.

4 We submit that a careful study should be
5 made as to the relative position of programs and practices
6 carried out by the practitioner, the Department of Public
7 Health and the voluntary agency, from the point of view of
8 each assuming its own proper responsibilities. I think
9 that it is desirable that somebody should assess the rela-
10 tionship of these three bodies, the medical practitioners
11 as a whole, the departments of Government and voluntary
12 agencies, because it seems to be that this is an essential.
13 We should first estimate the need which is shown in the
14 field and the facilities which are required for that need
15 and then investigate the possibilities that should be part
16 of the various components, and we think that that should be
17 done. It is most important that there should be a proper
18 integration of the public health program with any scheme
19 for medical care - "Health care" should not be split into
20 separate compartments.

21 My tenth point is that major advances have
22 been made in the Mental Health Program of the Province
23 with a major increase in expenditures on all phases. I
24 think you will find some information relating to that on
25 pages 79 to 85 of this brief. By way of approximation, I
26 think we spend now on mental health in this Province some-
27 thing like three times as much money as we spent as
28 recently as five years ago, and we have a program for the
29 care of the mentally afflicted, the health of the mentally
30 afflicted, that we think is excellent in its conception,



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5. ...carried out by the practitioner, the Department of Public
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27. recently as five years ago, and we have a program for the
28. care of the mentally afflicted, the health of the mentally



1 is modern in its outlook and has competent medical person-
2 nel. We have an active treatment hospital in this area
3 at Woodside across the harbour, Nova Scotia Hospital,
4 which has a new and modern admission building, there has
5 been a wide renovation of existing facilities, where they
6 are being brought up to a par with the new modern facili-
7 ties that are available, and we have it well-staffed, and
8 I am told by my officials it is not up to American mental
9 hospitals, but neither are they perfect, and we have
10 achieved a high standard of psychiatric care having regard
11 to our mentally afflicted population.



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1 In addition to that, we provide a program of
2 mental health clinics throughout the Province. These are
3 supported in the main, financially, by the Provincial
4 Government, but are made possible by the energy and initia-
5 tive of persons interested in this field in the local
6 community, and no doubt you will be hearing from the orga-
7 nizations dealing with them, and they can express their
8 own point of view, but we feel that the provision of these
9 clinics, which are being established on a regional basis,
10 and while we haven't quite achieved it yet, we expect in the
11 near future to get universal coverage, perhaps not in the
12 depth some people think we should have, but we think a
13 coverage in a useful and sensible approach to the problem,
14 because it brings the services of the doctors and psychia-
15 trists to the community, where it is readily acceptable,
16 and we think this is a very excellent part of our mental
17 health program.

18 I couldn't help but be struck by some obser-
19 vations made before your Commission when I was in Quebec,
20 with respect to the care of the mentally afflicted in this
21 country, and I hasten to say that those observations may
22 be applicable to some parts of the country of which I have
23 no knowledge, but they are certainly not applicable to this
24 Province, because we have an enlightened and scientific
25 approach to the care of the mentally afflicted in this
26 Province.

27 We do have in this Province something that
28 you will not find in any other Province in this field, and
29 this is considered by some to be a hangover from old times,
30 and that is that custodial care for the hopeless insane,



...of the ...

and no doubt you will be feeling more the same

...the ...

depth some people think we should have, but we think a

coverage in a variety and extensive approach to the problem

because it delays the arrival of the ... and ...

exists in the community, which is a really homogeneous

and we think this is a very excellent part of our mental

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no knowledge, but they are certainly not applicable to this

Province, because we have a ...

approach to the case of the ...

Province.



1 incurable insane, is provided still on the responsibility
2 of the municipalities. This has been traditional in this
3 Province. It has gone on for very many generations, and
4 only a matter of, I think, about three years ago, yes,
5 roughly three years ago, traditionally also, the entire
6 financial responsibility for this care of the hopelessly
7 insane was on the shoulders of the municipal government
8 and of the municipal taxpayers. Today, however, when a
9 municipal institution is brought to an acceptable standard,
10 and these are not difficult standards to attain, we do not
11 pretend that they are ideal in any way, but they do repre-
12 sent a very real advance in the care and treatment provided
13 to these people, who up to now were looked on as a mere
14 custodial problem, and for whom there was no hope. We
15 have had a re-appraisal of all these people confined in
16 these institutions, so that in the event if there is
17 change, or improvement, or the hope that active treatment
18 may be of benefit to the individual, the individual can be
19 taken, instead of being lost and forgotten in these municipi-
20 pal institutions, and transferred back to the active treat-
21 ment centre at the Nova Scotia Hospital, so I want to say
22 that we take a great deal of pride in what has been done
23 in respect to the care for the mentally afflicted in this
24 Province.

25 We think our program is an enlightened one.
26 We have been told that the principles which underly our
27 approach, and I am not of course referring to the mainte-
28 nance of the municipal institutions, because I understand
29 that in other Provinces this problem has been transferred
30 to the Provincial Government in its entirety, but our



It has gone on for very many generations, and

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1 approach to mental health clinics and so on has been
2 looked on as a very up-to-date way of dealing with the
3 matter, and we have had very many indications from other
4 Provinces that they are hoping to adopt a system similar
5 to the one we are now putting into practice.

6 To come back to the same thing of course,
7 I will perhaps leave this field by saying that again a
8 shortage of trained personnel is one of the blocks to
9 further expansion and more complete service. This, I
10 think, you will hear repeated many times as you go across
11 the country. My eleventh point is that all levels of
12 government are recognizing the importance of rehabilitation
13 programs - a shortage of facilities and personnel are a
14 handicap to the program throughout this Province - further
15 studies of the major needs should be instituted.

16 Our rehabilitation institutions are at the
17 moment classed as acceptable under the Hospital Insurance
18 Plan, and are financed under it, but there is not enough
19 of this sort of service available, and again if more is
20 to be made available, if new facilities have to be added
21 and new rehabilitation buildings provided, again we have
22 recourse only to that same fund of which I spoke before,
23 and which is available to the general hospitals and nurses'
24 residences, and that same fund is available for this, so
25 that this again adds to the demand made on that fund, and
26 underlines the necessity for additional funds being made
27 available at not too distant a time.

28 My twelfth point is that any plan of medical
29 care must be sufficiently flexible to be adaptable to
30 conditions as they exist in this Province.



To come back to the same thing of course,

I will perhaps leave this field by saying that again a

shortage of trained personnel is one of the big ones for

think, you will hear repeated many times as you go across

Government are recognizing the importance of rehabilitation

programs - a shortage of facilities and personnel are a

handicap to the program throughout this Province - further

studies of the major needs should be instituted.

Our rehabilitation institutions are at the

moment classed as acceptable under the Hospital Insurance

Plan, and are financed under it, but there is not enough

of this sort of service available, and again it were to

be made available, if new facilities have to be added

and new rehabilitation buildings provided, again we have

recourse only to that same fund of which I spoke before,

and which is available to the general hospitals and nursing

residences, and that same fund is available for this, so

that this again adds to the demand made on that fund, and

underlines the necessity for additional funds being made

available at not too distant a time.

My twelfth point is that any plan of medical

must be sufficiently flexible to be adaptable to

as they exist in this Province.



1 That, perhaps, Mr. Chairman, is an insulting
2 thing to say to you. I would take it for granted that
3 differences in geography, differences in habits, even in
4 health levels, would be all matters which would be taken
5 into consideration if and when you reach the point when
6 you are recommending some sort of program. In any event,
7 it certainly should be flexible.

8 It will not be of very great value to this
9 problem if a plan were to be suggested for which the
10 Federal Government was going to make certain sums of money
11 available and if they set a certain standard and say you
12 can have this and we will pay so much provided you match
13 it. This sometimes has been the difficulty of offers from
14 the Dominion Government, in that they make their grants on
15 condition of us making certain programs. If you have to
16 match, it is not easy. I have heard representations made
17 with respect to, for example, a matter that is outside the
18 scope of this Commission, the provision of funds to assist
19 in the building of a Trans-Canada Highway, and it has been
20 argued, and I think that it is an argument with some merit,
21 that it is one thing to say that you will pay half of the
22 cost of the undertaking to a Province that has no difficulty
23 whatever in raising its half, and it is another thing to
24 say it to a Province that has very stringent financial
25 conditions, and the benefit of the grant is perhaps more
26 apparent than real if you put a burden on the Province.

27 So I respectfully suggest Mr. Chairman, that
28 if and when you come to the point where you are recommen--
29 ding a plan, you maintain that degree of flexibility to
30 allow those Provinces less endowed with financial resources



1 to be able to take the benefit of the plan. Not for them
2 to have to say we like the plan but it is too rich for our
3 blood. We would like it sufficiently flexible to be able
4 to fit it into the availability of the resources we are
5 able to allocate for that purpose.

6 Lastly, I say that in view of the many and
7 varied aspects of health services, it will not be possible
8 to implement all the improvements necessary at any one
9 time. Therefore, serious thought should be given to the
10 question of priorities.

11 I think it should be clear, at least we
12 understand that it will not be possible to implement all
13 the improvements necessary at any one time, and therefore
14 we believe that the representations that will be made to
15 you, and they will be in many and varied fields, there
16 will be many groups coming forward and urging upon you
17 that you should recommend advances to be made, or steps
18 to be taken, or assistance to be provided in a variety of
19 fields, and I am sure that in each one of those fields,
20 taken separately, they will be able to establish a good
21 case, and convince you that yes, in the field of A, B or
22 C, such-and-such is a desirable end, and we should do
23 everything we can to assist in achieving that end. Never-
24 theless, the matter is a whole picture. You have to look
25 at the entire composite, and we believe that there are
26 certain things that are required that are of more impor-
27 tance than others, in that if you are not going to be able
28 to do all the things required at one time, you should give
29 greatest thought and care to the selection of those pro-
30 jects or those areas in which you believe assistance is



to take the benefit of the plan. Now for them
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to be taken, or assistance to be provided in a variety of
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at the entire composite, and we believe that there are
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tance than others, in that if you are not going to be able
to do all the things required at one time, you should give
greater thought and care to the selection of those pro-



1 most required, in which you believe the need is greatest,
2 and that you should, in making your recommendations,
3 certainly list these fields in the order of the priority
4 which it appears to you is proper.

5 Mr. Chairman, that is all I have to say on
6 this occasion. I repeat again that I thank you for the
7 opportunity of being heard. I reiterate that this is in
8 the nature of a preliminary submission. I want to point
9 out, as you did, Mr. Chairman, when we began, that it is
10 a submission from the Government of Nova Scotia, although
11 our agenda says it is the submission of the Nova Scotia
12 Department of Public Health. In that respect, I want to
13 say that it is obvious that the information contained in
14 this brief was compiled in the Department of Public Health.
15 We are in very great debt to the Deputy Minister, who
16 served as a committee head with other departments in
17 compiling the brief. In that sense, the brief is the
18 work of the Department of Public Health, but it is submit-
19 ted to you as the brief of the Province of Nova Scotia,
20 or at least Part I of that brief, and we hope that when
21 your hearings are coming to a close, we will submit to you
22 another part of that brief, in which I hope there will be
23 a more definite indication of our position on these
24 problems, and our thoughts on which direction your recom-
25 mendations ought to lie.



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2 the need is greatest, in which you believe the need is greatest,

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5 Mr. Chairman, that is all I have to say on

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20 or at least part I of that brief, and we hope that when

21 your hearings are coming to a close, we will submit to you

22 another part of that brief, in which I hope there will be

23 a more definite indication of our position on these

24 matters, and we hope that this will be of some

25 mention ought to be.



1 PROVINCE OF NOVA SCOTIA

2 The Government of the Province of Nova
3 Scotia welcomed the appointment by the Government
4 of Canada of a Royal Commission to inquire into and
5 report upon all facets of health services for
6 the people of Canada.

7 The Royal Commission on Dominion-Provincial
8 Relations compiled a considerable amount of informa-
9 tion on the same matter and reported in the year 1940.
10 A war has intervened and in the past twenty years
11 great changes have taken place. The changes have
12 been so great that the Royal Commission on Health
13 Services will be examining a situation entirely
14 different from that which existed in 1940.

15 The Government of Canada has accepted a
16 degree of responsibility for health services in Canada,
17 as evidenced by the extent to which it has assisted
18 in the establishing and maintaining of health services
19 through a system of grants. The Government of Canada
20 is sharing in the cost of providing prepaid hospital care
21 for the people of Canada.

22 In view of these changes, it is an opportune
23 time to again examine the whole matter of health
24 services available to the people of this nation.

25 The Royal Commission on Health Services has
26 been given broad Terms of Reference, and its findings
27 and recommendations will have an impact on the life
28 of every Canadian. The Royal Commission is composed
29 of distinguished Canadians, well qualified to discharge
30 the trust conferred upon them.

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and recommendations will have an impact on the life

of every Canadian. The Royal Commission is composed

of distinguished Canadians, well qualified to discharge

the trust conferred upon them.



1 We welcome the Commission to the Province
2 of Nova Scotia and we wish to assure it of our
3 unqualified support and co-operation.

4
5 (Signed) R. L. Stanfield

6 Premier

7 Province of Nova Scotia
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...support and co-operation.

(Signed) R. L. Stanfield

Premier

Province of Nova Scotia

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HEALTH SERVICES - NOVA SCOTIA

1. On the premise that access to all health services necessary to maintain normal health should be available to every citizen of Canada, this brief will review (A) the health services required by the "average" citizen of Nova Scotia during his or her lifetime; and (B) the health services required for unusual "health conditions" which may be present at birth or develop during the lifetime of a significant segment of the population of Nova Scotia.

2. A review will be made of the present situation in Nova Scotia in relation to the above, with an indication of the areas needing attention now and in the future.

3. This brief will be made up of two parts:

Part I - A review of the present health services situation in Nova Scotia

Part II - Requirements and Planning for the future.

(Part II of this brief will be submitted at a later date)

PART I

4. A. The average citizen of Nova Scotia, during his or her lifetime, will require or make use of the following health services:

1. Physician care; including preventive services, general practitioner and specialist care.

2. Hospital care - including Maternity Hospital

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4. A. The average citizen of Nova Scotia, during his or her lifetime, will require or make use of the following health services:

1. Physician care; including preventive services, general practitioner and specialist

hospital care - including Maternity Hospital



- 1 (may be ward of general hospital).
- 2 - Children's Hospital (may be ward of
- 3 general hospital).
- 4 - General Hospital, including diagnostic
- 5 services and out-patient services.
- 6 3. Diagnostic Services (X-ray, Pathology, etc.)
- 7 4. Drugs and biologicals for prevention and
- 8 treatment
- 9 5. Nursing care - home, hospital, industry, etc.
- 10 6. Dental care
- 11 7. School Health Services
- 12 8. Community Planning Services - housing -
- 13 sub-divisions
- 14 9. Ancillary medical services
- 15 10. Recreation and Physical Fitness Services
- 16 11. Nutrition Services
- 17 12. Public Health Services - control of environment
- 18 - prevention of disease
- 19 13. Health Services by voluntary associations,
- 20 e.g., Red Cross
- 21 14. Health Services through certain official
- 22 agencies, e.g., Department of Agriculture;
- 23 Department of Fisheries
- 24
- 25 5. B. In addition, the following health services
- 26 will be required by a significant proportion
- 27 of the citizens of the Province:
- 28 1. Mental Health Services - Retarded Children
- 29 - Prevention
- 30 - Acute Mental Disease
- Chronic Mental Disease



2. Tuberculosis Services
3. Cancer Services
4. Special Hospital Services - Convalescent
- Chronic
5. Licensed Nursing Home Services
6. Services in the home for convalescent, chronic
ill, aged (Domiciliary Care)
7. Rehabilitation Services (general - mental - Tbc.)
8. Blood and related products
9. Health Services by voluntary associations for
special conditions - muscular dystrophy, etc.
10. Research.

PHYSICIAN CARE

6. This section attempts to deal with all phases of physician care - prevention of disease and treatment, both by the general practitioner and the specialist.

In a modern society, it is expected that the following basic services should be available from practising physicians to all citizens who require such services.

- (a) Pre and post natal care.
- (b) Obstetrical care.
- (c) Non specialist paediatric care, including complete pre-school examination.
- (d) Prevention of infectious diseases by immunization procedures.
- (e) Physician care to children and adults - home, office, hospital - including health counselling.

1111. aged (Homboldt) (1911)

Reimbursement Services (General - Mental - Physical)

Blood and related products

Health Services by voluntary associations for

special conditions - medical diagnosis, etc.

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(a) Pre and post natal care.

(b) Obstetrical care.

Complete pre-natal examination.

(c) Prevention of infant mortality.

Education of children.

(e) Physicians care to children and adults -



- (f) Regulat physical examination - to prevent disease - to detect early disease.
- (g) Simple laboratory tests.
- (h) Advice regarding specialist physician care.
- (i) Provision of advice and prescription for drugs.
- (j) Advice and authority for laboratory and radiological examinations.

7. In order to properly provide the basic services noted above and other medial services to be noted later, there should be available one physician for a specific number of citizens - the number who can be looked after by a single physician is still a subject of debate.

In England, each general practitioner is allowed a total of 3,000 patients - but is must be remembered that he has no hospital patients to attend and many of the minor invesigations carried out by a Canadian general practitioner are referred to a specialist, a clinic, a laboratory, or a hospital. Most patient lists in England and Wales are below the maximum noted.

8. Another factor is the type of practice with relation to density of population. A city practitioner with his patients in a mile or so radius and good transportation could, conceivably, look after a larger number of patients than a rural practitioner with long distances between office and patients, etc.

9. There is probably an average number of

Provision of advice and investigation for

Advice and authority for laboratory and
radiological examinations

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8. Another factor is the type of practice
with relation to density of population. A city
practitioner with his patients in a wide area has to
and good transportation could, conversely, look after
a larger number of patients than a rural practitioner.



1 patients which could be used for discussion purposes
2 but this is a difficult figure to obtain on a reliable
3 basis at present. Some computations take in all the
4 physicians on the Medical Register, despite the fact
5 that some are retired, some are teachers only, some
6 are in administration only, others are in military
7 or hospital service. It is presumed that reliable
8 figures for Canada will become available to the
9 Commission - just how valuable comparisons with other
10 countries' figures are is a matter of conjecture.

11 10. With regard to specialist physicians, it
12 is again difficult to obtain specific information
13 in order to establish a physician-patient ratio -
14 probably it would be more workable to establish a
15 physician-population ratio in the case of specialists
16 who deal largely with patients referred from other
17 physicians.

18 11. Figures from a study carried out in 1960
19 would indicate that the physician-population ratio as
20 of December 31st, 1960, for Canada was 1:879 - for
21 Nova Scotia this was 1:1013. For comparison, New
22 Brunswick was 1:1362, Ontario 1:730 and Manitoba
23 1:879.

24 12. For Nova Scotia to reach the all Canada ratio
25 alone would mean an addition of 110 physicians to
26 our present supply.

27 INSUFFICIENT PHYSICIANS IN PRACTICE

28 13. Based on figures for Canada and other
29 Provinces, it would appear that there is a definite
30

in administration only, others are in military

or hospital service. It is pointed out that

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countries' figures are in a matter of comparison.

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of December 31st, 1960, for Canada was 1:579 and

would indicate that the physician-population ratio was

of December 31st, 1960, for Canada was 1:579 and

Brumwell was 1:1805, Ontario 1:183 and Manitoba

12. For Nova Scotia the ratio was 1:1,000 and

alone would mean an addition of 100 physicians to

our past of 1960.

PHYSICIAN-PATIENT RATIO IN CANADA

13. Based on figures for Canada and other

figures for other countries, it is estimated that



1 actual shortage of physicians at present in the
2 Province of Nova Scotia - if increased demands
3 for services continue this overall shortage will
4 become more acute. It is probably that the inflow
5 of "foreign" physicians will not continue on the
6 present scale in the future under present conditions.

7 DISTRIBUTION OF PHYSICIANS

8 14. In the Western world urbanization and im-
9 proved transportation has affected the physician in a
10 very definite way. As a result, in Nova Scotia we have
11 a concentration of physicians in urban areas with
12 resultant poor coverage in the rural areas. This
13 is even more striking in the specialist physician
14 field where over 70 per cent of specialists are in
15 the Halifax City area with consequent poor coverage
16 of the rest of the province. The Halifax-Dartmouth
17 Metropolitan area, with a population of about 200,000,
18 has 165 practising specialists, while the Sydney
19 Metropolitan area with a population of 125,000 has
20 only 37.

21 15. Several factors appear to influence the
22 location of physicians, among these are (not neces-
23 sarily in order of importance)

- 24 (a) Income available
- 25 (b) Hospital facilities
- 26 (c) Educational and social facilities
- 27 (d) Housing and local conditions
- 28 (e) Background of physician and wife
- 29 (f) Desire for specialization
- 30 (g) Presence of a medical school

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- (e) Background of physician and wife
- (f) Desire for specialization
- (g) Presence of a medical school



16. With specialist physicians, a concentration of population seems to be a major factor, especially if related to suitable hospital facilities - again, income is a major item as presumably only with large populations can a specialist income be earned under present methods of remuneration. This, of course, leads to the suggestion that with no change in the present methods of remuneration of specialists, many areas where such services are justified will remain without such specialist services in the future.

17. It is apparent that in order to provide a more uniform service to all citizens, there should be an improvement over the present distribution of physicians and specialist physicians. It would appear that in order to achieve this, there should be developed some method for properly remunerating physicians, especially in many rural areas of the province.

18. Various suggestions have been made, and in some cases attempted, as to how an improved distribution of physicians could be achieved -

1. Municipal and/or Provincial Government subsidies to physicians in specified rural areas (now in use in a limited way).

2. Employment of physicians by Government and assignment to specified areas at an agreed remuneration.

3. Provision of adequate housing and office in specified rural areas.

4. Financial assistance to undergraduates



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1 with agreement to work out loans by practising for
2 a specified period in rural areas, with subsidy, etc.,
3 if required.

4 5. Capitation scheme with limit of number
5 of practitioners in urban areas - excess would prac-
6 tice in rural areas.

7 6. Insurance coverage of all citizens of
8 the province with comprehensive medical coverage so
9 that a physician would be compensated for all necessary
10 services given - this would leave a comparatively small
11 number of areas where a subsidy would be required
12 due to a scattered population.

13 INSUFFICIENT NEW PRACTITIONERS

14 19. Figures are available which indicate that
15 an insufficient number of new practitioners are estab-
16 lishing in Nova Scotia to keep pace with losses from
17 the profession by death, retirement, and increasing
18 population, to say nothing of increases necessary
19 because of our present high physician/patient ratio.

20 20. It has been suggested, with some justifi-
21 cation, that too few students interested in practice
22 in Nova Scotia are entering the medical schools -
23 various reasons are given for this but one of the
24 important ones might be the high cost of obtaining
25 the necessary training over an eight year period after
26 leaving High School. Linked with this is the loss
27 of earning power during this period when most students
28 are in their twenties. This is the time when the
29 average person becomes interested in marriage - the
30 average medical student would appear to be in no

an agreement to work out loans by practising for a specified period in rural areas, with subsidy, etc.,

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of earning power during this period when most students

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average person becomes interested in marriage - the



1 financial position for such a step without outside
2 assistance - many leave Medical School with a sub-
3 stantial debt.

4 21. If specialization is being considered then at
5 least an additional four years is required - this
6 often extends to seven years or more, so that a
7 specialist would require a minimum of 8 plus 4 years
8 (12), after leaving High School, before he could be in
9 a position to be earning any significant income.

10 22. In many of the European countries a large
11 proportion of medical students and physicians are
12 females - in this continent only a small number of
13 women students and practitioners are available.

14 Possibly more consideration should be given to the
15 recruitment of female medical students.

16 23. It is suggested that a scheme for assisting
17 medical students might be of value in increasing
18 the overall number of physicians and at the same
19 time provide a means of obtaining physician services
20 for rural areas. The graduate might, by providing
21 service in a rural area, have his debt wiped off by
22 return in service over a period of time.

23 24. In this way, he would also be gaining im-
24 portant experience and if later he went on to
25 specialization the previous practitioner experience
26 should be of great value to him and his patients.

27 A study of medical requirements for training would
28 indicate that many of our specialists have never
29 dealt with other than a hospital patient before enter-
30 ing on the practice of their specialty - it has been

21. If specialization is being considered then at least an additional four years is required - this often extends to seven years or more, so that a specialist would require a minimum of 8 plus 4 years (12), after leaving High School, before he could be in a position to be earning any significant income.

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23. It is suggested that a scheme, or assisting medical students might be of value in increasing the overall number of physicians and at the same time provide a means of obtaining physician services for rural areas. The graduate might, by providing service in a rural area, have his debt wiped off by return in service over a period of time.

24. In this way, he would also be gaining important experience and if later he went on to specialization the previous practitioner experience should be of great value to him and his patients. A study of medical requirements for training would indicate that many of our specialists have never dealt with other than a hospital patient before entering



1 suggested for several, if not all specialties that a
2 compulsory period of general practice could well
3 precede the specialty study.

4 25. A brief review of present physician figures
5 in Nova Scotia would appear to show:

6 (1) That we do not have sufficient
7 physicians.

8 (2) That the present distribution of
9 physicians throughout the province is unsatisfactory,
10 both from the physician service and specialist ser-
11 vice point of view.

12 (3) That insufficient physicians interested
13 in practice in Nova Scotia are being graduated from
14 Dalhousis and other Medical Schools to meet present
15 and future requirements in Nova Scotia.

16
17 PREVENTION OF DISEASE BY THE PRACTISING
PHYSICIAN

18 26. The modern physician can do and does much
19 in a preventive way in his practice - many diseases can
20 be prevented - others can be modified.

21 27. Among the diseases considered preventable
22 by modern methods are the following: (drugs and
23 biologicals for prevention are available to any
24 practitioner in this province).

- 25 1. Smallpox
- 26 2. Diphtheria
- 27 3. Whooping Cough (Pertussis)
- 28 4. Tetanus
- 29 5. Poliomyelitis
- 30 6. Measles

agreed for several, if not all specialties that a
compulsory period of general practice could well

25. A brief review of present physician figures

in Nova Scotia would appear to show:

(1) That we do not have sufficient

(2) That the present distribution of

physicians throughout the province is unsatisfactory,

both from the physician service and specialist car-

(3) That insufficient physician interest

in practice in Nova Scotia are being graduated from

Dalhousie and other Medical Schools to meet present

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PREVENTION OF DISEASE BY THE PRACTISING PHYSICIAN

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1. Smallpox

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3. Tetanus



1 7. Rheumatic fever

2 8. Typhoid and Paratyphoid

3
4 28. There is a tendency by the public to expect
5 "free" preventive services even in non epidemic times
6 - yet, in fact, the procedures for prevention are pro-
7 perly the responsibility of the individual citizen and
8 the individual physician. In this province, even in
9 clinics organized by the Department of Public Health, such
10 procedures are carried out by practitioners except for
11 clinics in the City of Halifax and some rural municipali-
12 ties where municipal health officers (physicians)
13 carry out the procedures.

14 29. It is felt that prevention of disease would be
15 greatly accelerated if there were not a financial barrier
16 between the physician and the citizen.

17 30. In addition to preventing disease through the
18 use of drugs and biologicals the modern physician can do
19 and does much in a preventive way as part of his practice,
20 e.g.,

21 Diabetes - Control of overweight in patients,
22 especially those with a family history of diabetes;
23 routine urine examination on all patients.

24 Heart Disease - Control of overweight impor-
25 tant.

26 Cardiovascular and renal disease -- dietary
27 control can do much to prevent or control the diseases.

28 Mental Disease - It has been stated that the
29 family physician can be a major factor in the preven-
30 tion of mental disease and the treatment of early
 cases.

8. Typhoid and Paratyphoid

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1 Nutrition Problems - By proper advice to
2 mothers on nutritional problems of children such
3 diseases as rickets and scurvy can be prevented.

4 Prevention of Crippling - By proper advice to
5 parents of children with congenital deformities future
6 crippling disease can often be prevented. Protection
7 of pregnant women against German measles.

8 Pre and Post Natal Care - Can do much to ensure
9 a normal child and a healthy mother.

10 Preschool Examination of Children - Can find
11 early defects which can be treated to ensure a healthy
12 school child.

13 Dental - The physician often sees children
14 before the parents realize dental care is needed for
15 orthodontic procedures - cavities, poor occlusion, extra
16 teeth, etc. Correction of these defects can improve
17 the child physically as well as mentally.

18 Regular Physical Examinations - Often bring
19 to light unsuspected conditions which can be successfully
20 treated, especially important with relation to cardiac
21 disease, diabetes, tuberculosis and cancer. Certain
22 eye diseases, such as early glaucoma are also found on
23 such examinations - if not found and treated early
24 usually leads to blindness.

25 Arthritis - Early discovery and treatment
26 often prevent crippling in later life.

27 High Blood Pressure - Early discovery and
28 modern treatment can prevent or postpone many later
29 accidents.

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THE PHYSICIAN AND COMMUNITY PUBLIC
HEALTH

31. The physician in his role as an educated citizen can also be an important factor in the development of community preventive measures, such as chlorination of water supplies, fluoridation of water supplies, proper water and sewage installations, proper housing, water safety campaigns, prevention of accidents in home and industry, etc.

32. It has been stated, with some justification, that the medical profession is one which works for its own elimination. By developing and using preventive measures the profession is preventing future disease - but one of the difficulties is to get the public to accept the proffered treatment despite the combined efforts of the practitioners and others interested in prevention of disease. For example, many people are still not protected against poliomyelitis - our greatest loss of life among the communicable diseases is from whooping cough - even if children recover they often have crippling conditions as a result.

33. Since many mothers do not return to the physician for post natal care and advice about the new baby, the Department of Public Health and the Victorian Order of Nurses is attempting through visits of Public Health Nurses to persuade mothers to visit their physician and to have the baby examined and given preventive treatment against communicable diseases such as whooping cough. Medical School authorities are most interested in this campaign

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34. One of the difficulties in this campaign is the shortage of physicians in some rural areas. Many people still do not have a car to get to the doctor - cost is also a factor in preventing patients from visiting or calling a doctor. As a result the campaign is more successful in the urban than the rural areas.

POST GRADUATE EDUCATION OF PHYSICIANS

35. Due to the increasing complexity of modern medicine, new discoveries and changes in concept, the importance of the modern physician keeping abreast of new methods, new equipment and new drugs is apparent, if he is to give adequate service to the public.

36. Physicians, medical societies and the Medical School have recognized this need - it is stated that Nova Scotia has the most advanced arrangements for postgraduate education, but the individual physician must decide to accept and arrange time for such courses. It is stated that for various reasons not enough of our physicians attend such courses which are available - as a result it may be that certain physicians are not providing adequate "modern" care to patients.

37. The present situation in Nova Scotia is for a physician to be licensed by the Provincial Medical Board when he starts to practise in the province - no further licensing or examination is required. If annual licensing were required, this might be combined with a requirement for "refresher" courses at stated intervals. In this way, there could result an improvement in the

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In this way, there could result an improvement in the

quality of medical practice. The newly formed "College of General Practice" uses this principle by requiring its members to spend at least a specified number of hours each year in postgraduate study.

38. It is important to note that the majority of physicians in Nova Scotia are reported to keep up with modern trends and methods by reading, attending medical conventions and refresher courses.

SPECIALIST PRACTICE OF MEDICINE

39. The modern practice of medicine requires specialization in order to deal with difficult and complicated diagnosis and treatment. In order to qualify as a specialist, such physicians must be so indicated by the Royal College of Physicians or Surgeons of Canada or some similar recognized body. This may take the form of "Certification" or "Fellowship" - the latter is the higher qualification. In order to practice successfully as a specialist, there must be available to the specialist special diagnostic and treatment facilities - at present these are usually only available in the larger centres of population with large hospitals, laboratories and other facilities.

40. As a result, with minor exceptions, with minor exceptions, the medical specialists in Nova Scotia are largely centered in the Halifax area. The presence of the Medical School and the Victoria General Hospital are, of course, major factors. In recent years there has been some improvement in other areas due to the improvement in hospital, x-ray and laboratory facilities.

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41. It has been stated that there are too few or no specialists in many areas in such fields as Internal Medicine, Obstetrics and Gynecology, Eye, Ear, Nose and Throat, Orthopedics, Paediatrics, Dermatology, Neuosurgery, Psychiatry, Surgery and Physical Medicine.

42. There are many reasons given for the shortage of specialists in certain areas - whatever the reasons, some system must be evolved to give better specialists physician coverage for many areas of the province. Even with modern transportation, distances are too great for adequate coverage from the large centres.

PHYSICIAN CARE OF THE MEDICALLY INDIGENT

43. A "medical indigent" might be defined as a person, who, while capable of providing food, shelter and clothing for himself and/or his family, does not have income sufficient to pay for medical care or medical insurance coverage at the time such services are required. The term of course also includes persons who are "indigent" in the ordinary sense or are receiving living assistance from some level of government.

44. It is undoubtedly true that all physicians cheerfully or otherwise look after a large number of patients on a free basis - indeed, not too many years ago it was stated in medical circles that a physician only expected to collect for about 60 - 70 per cent of the services he provided. Probably physicians are now better business men and this percentage has been increased but a large amount of free service is still provided.

45. Despite the generous providing of such free

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45. Despite the generous providing of such free



services by physicians, there is often a feeling of "charity" associated and many persons delay visiting their physician until disease is far advanced - others hesitate to bring their children for immunization - pregnant women do not come in early enough or not at all for proper pre-natal care. It is a fair statement that inability to pay keeps many people from visiting or calling a physician when such services are needed and essential. It is also true that many factors other than financial keep people from calling a physician.

46. It is difficult to estimate just how many of our citizens are "medically indigent" but we do have information on certain groups - these citizens and their dependents receive assistance from various governments - therefore, their income is nil or so low as to merit assistance for food, clothing and shelter - the figures are as of August 15, 1961:

(a) Recipients of Blind Persons Allowance	785
(b) Recipients of Disabled Persons Allowance	2711
(c) Recipients of Provincial Social Assistance	12345
(d) Recipients of Old Age Assistance	5400
	<hr/>
	21,241

47. Taking the estimated population of the Province as 746,000, the 4 groups above represent slightly less than 3 per cent of the population.

48. (e) In addition to the above there are 11,137 persons receiving Municipal Assistance - again, based on a means test.

49. By adding (e) to (a) (b) (c) and (d), we get



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By adding (a) to (d) and (e) we get



a total of 32,378 who can safely be regarded as medically indigent - 4.3 per cent of the total population.

50. (f) A proportion of citizens receiving Old Age Pensions.

In 1952 the means test basis for Old Age Pensions was discontinued - as a result a larger number of persons receive Old Age Pensions now. By using the ratio between these two groups, it is estimated that in 1961 there are some 25,000 persons receiving Old Age Pensions who are medically indigent.

51. By adding (f) to the above groups, we now have a total of 57,378 medically indigent - 7.6 per cent of the total population.

52. (g) Children under care of Director of Child Welfare and Children's Aid Societies. 2289

(h) Children in Training Schools 329

(i) Nova Scotia School for Boys 125

(j) Children in other child caring institutions 204

(k) Nova Scotia Training School 180

53. The total of (g) (h) (i) (j) (k) thus gives a total of 3127 children who are medically indigent giving a grand total to date of 60,505 or 8.1 per cent of the total population.

54. (1) Patients in Municipal Homes 575

This gives a total of 61,080 who may be regarded as medically indigent or 8.2 per cent of the total population. Just how many others in the popu-



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51. By adding (f) to the above groups, we now have a total of 57,378 medically indigent - 10.7 per cent of the total population.

52. (g) Children under care of Director of Child Welfare and Children's Aid Societies.
- | | |
|-----|---|
| 359 | (h) Children in Training Schools |
| 128 | (i) Nova Scotia School for Boys |
| | (j) Children in other child caring institutions |
| 209 | |
| 100 | (k) Nova Scotia Training School |

53. The total of (g) to (k) is 796.

a total of 58,344 children who are medically indigent giving a grand total to date of 62,502 or 8.1 per cent of the total population.

54. (l) Patients in Municipal Homes

This gives a total of 61,083 who may be regarded as medically indigent or 8.2 per cent of the total population. Just how many others in the population



1 lation are medically indigent is difficult to say. It
2 would probably be reasonable to double this figure
3 - thus 120,000 or 16 per cent of the population could
4 be so regarded.

5 55. How do the 120,000 obtain physician services?

6 (1) A limited medical service is provided
7 to 9978 recipients and dependents receiving Blind
8 Persons Allowance and Provincial Social Assistance.
9 The Government of Nova Scotia pays the Nova Scotia
10 Medical Society \$1.30 per month for each dependent -
11 in turn the Society contracts with Maritime Medical
12 Care as its agent to administer the fund - the physi-
13 cians of the Province provide the service on a fee
14 basis.

15 (2) A medical service based on salaried
16 part time physicians is provided to children in various
17 institutions - in all about 600 are looked after in this
18 way.

19 (3) A medical service based on salaried
20 part time physicians is provided to 15 municipal homes
21 with about 575 patients.

22 The total of (1) (2) and (3) is 11,153. Thus
23 11,153 out of a possible 120,000 medically indigent
24 are provided with some form of physician service - about
25 10 per cent.

26 55. (4) Thus, about 109,000 persons apparently
27 receive part of all of their medical care on a free
28 basis from physicians, clinics, etc. Certainly,
29 this group even if they could pay for the odd office
30 call could not pay for a "catastrophic" illness such as

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this group even if they could pay for the odd illness
call could not pay for a "catastrophic" illness such as



1 a serious operation.

2 56. It should be noted that of the 11,153 who
3 are provided with medical care, in most cases the
4 coverage is not "comprehensive" - there are numerous
5 exclusions - the cost of comprehensive coverage would
6 be much higher than that paid at present.

7
8 MEDICAL CARE TO VETERANS

9 57. All veterans are eligible for treatment at
10 Camp Hill Hospital which has a staff of medical
11 consultants who are remunerated either on a salary or
12 per diem basis. A proportion of the veterans are in
13 the "medically indigent" class and should be added to the
14 total in the foregoing section.

15 58. In addition to medical treatment at Camp Hill
16 Hospital, certain eligible veterans can be treated by
17 their doctor of choice and the fee paid by Veterans
18 Affairs based on a schedule of rates.

19 REMUNERATION OF PHYSICIANS

20 59. This is provided in a variety of ways, the
21 most common still being a fee for services as a result
22 of a private arrangement between the physician and the
23 patient. Fees are usually based on a scale set up and
24 agreed upon by the Medical Society of Nova Scotia -
25 there is no legal requirement for the application
26 of such a scale. It is stated, and no doubt a fact,
27 that in dealing with non insured patients, that the
28 average physician only collects for 60 - 80 per cent
29 of the work which he carries out - all physicians expect
30 to provide a reasonable amount of free care for the



1 indigent with a consequent adjustment of the fee
2 schedule for those who can pay - thus, the strong
3 help the weak.

4 60. It is suggested that if an insurance scheme
5 became available to provide full payment to physicians
6 for all services, that the present fee schedule might
7 be scaled downward since no "free work would be
8 involved - there would be 100 per cent collection of fees

9 61. Other methods of remunerating the physicians
10 are -

11 (a) Medical Insurance Coverage of Patients
12 by Private Insurance Companies. It is difficult to
13 obtain figures on just how many are so protected
14 and just what is the degree of coverage. It would
15 appear that few have "comprehensive" coverage for all
16 illnesses. Present figures would indicate that about
17 30 per cent of the population have some form of "private"
18 insurance coverage.

19 62. (b) Through Maritime Medical Care. A
20 physician sponsored and operated insurance scheme -
21 again, services provided are not fully "comprehensive"
22 due to certain exclusions. Further, under this scheme,
23 specialists are allowed to make additional charges
24 over and above the schedule of the Nova Scotia Medical
25 Society.

26 63. This medical care scheme has been quite suc-
27 cessful and the number of persons covered under this
28 scheme has been steadily increasing - at present about
29 140,000 are so covered.

30 64. (c) Through the "Blue Shield" scheme,



operated by the Maritime Hospital Service Association.
Again this is not "comprehensive" coverage - it
would appear about 27,000 are covered under this scheme.

65. (d) Through the plan offered by the
Federal Government to Federal employees -- apparently
about 10,000 persons are covered.

66. (e) Through a check off capitation scheme
in operation in certain coal mining areas.

67. (f) Through payments from the "Sick Mariners
Fund" operated by the Government (Federal).

68. (g) Through payment of salaries - this
applies to physicians in Armed Forces - in Government
institutions - in industry, etc. If we include medical
teachers in Universities and Public Health personnel,
it is estimated that over one-sixth of all physicians
in Nova Scotia are being remunerated on a salary basis.
Many physicians receive their income from a part time
alaried position plus private practice on a fee for
service basis. Estimates would indicate that some
100 physicians receive 80 per cent or more of their
income from salary.

69. (h) Through payments from the Workmens
Compensation Board on a fee basis.

70. (i) Through payments by Department of
Veterans Affairs. Depending on who provides the
service the remuneration may be by

(a) Salary

(b) Per Diem Allowance

(c) Fee for service - 90 per cent of Nova Scotia
Medical Society schedule.

Again this is not "comprehensive" coverage - it

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service the remuneration may be by

(a) Salary

(c) Fee for service - 80 per cent of Nova Scotia



1 To sum up the subject of Physician Ser-
2 vices in Nova Scotia, it would appear:

3 1. There are an insufficient number of
4 physicians practising in Nova Scotia in relation to the
5 population.

6 2. The distribution of physicians is such as
7 to relatively overemphasize the service to urban
8 areas with resultant poor coverage of rural areas.

9 3. The same may be stated with regard to
10 "specialist" practice - the distribution problem is
11 even more evident and more acute in some specialties.

12 4. That an improved system should be
13 evolved to require all physicians to keep abreast of
14 modern methods of medical care.

15 5. That more emphasis should be placed on
16 the prevention of disease by physicians.

17 6. That some method must be developed in
18 order to increase the number of medical students,
19 general practitioners and specialists.

20 7. That more female students and physicians
21 should be encouraged in the practice of medicine.

22 ANCILLARY MEDICAL SERVICES

23 72. Under this heading will be discussed certain
24 personnel who are essential in the providing of health
25 services.

26 LABORATORY TECHNICIANS

27 73. At present there are two training schools
28 operating in the province - the course is of 18 months.
29 After completing the course, examinations can be taken
30



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physicians practicing in Nova Scotia in relation to the

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It is recommended that the following

should be encouraged in the practice of medicine.

ANALYSIS OF MEDICAL EDUCATION

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personnel who are essential in the providing of health

LABORATORY TECHNICIANS

7. At present there are two training schools

operating in the province - the course is of 18 months.

After completing the course, examinations can be taken



1 leading to designation as a Registered Technician
2 (R.T.). Qualified technicians are in short supply
3 and several hospitals are without personnel.

4 74. Up to the present most persons taking the
5 course have been girls with Grade XII; after comple-
6 tion of the course there are major losses due to
7 marriage, change of location, etc., so that a con-
8 tinuing major training program must be continued.

9 75. Efforts are being made to interest more
10 male students in the course in order to establish a
11 more stable staff - however, present salary levels are
12 not such as to attract personnel with the necessary
13 qualifications.

14 76. Bursaries are available to assist in training.

15 X-RAY TECHNICIANS

16 77. Much of what has been said about laboratory
17 technicians applies also to this group. The major
18 training school is in the Victoria General Hospital
19 - the supply of X-ray technicians is larger and after
20 training are more apt to remain as an X-ray technician
21 for longer periods than laboratory technicians.
22 However, the shift is such as to make it necessary to
23 carry on a continuous training program.

24 78. Bursaries are also available for the train-
25 ing of X-ray technicians.

26 PHYSIOTHERAPISTS

27 79. With the increased emphasis on rebaillitation
28 the demand for physiotherapists has greatly increased
29 - the supply is far short of the demand. Such
30

and several hospitals are without personnel.
course have been given with Grade XII; after completion of the course there are major losses due to

marriage, change of location, etc., so that a continuing major training program must be continued.

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X-RAY TECHNICIANS

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technicians applies also to this group. The major

training school is in the Victoria General Hospital

- the supply of X-ray technicians is larger and after training are more apt to remain as an X-ray technician

However, the shift is such as to make it necessary to

carry on a continuous training program.

78. Bursaries are also available for the training of X-ray technicians.

79. With the increased emphasis on rehabilitation

the demand for physiotherapists has greatly increased

- the supply is far short of the demand. Such

personnel are required for hospitals, rehabilitation Centres, home and industry - anywhere remedial exercises and massage, etc., will benefit a patient.

80. Bursaries are again available for training.

OCCUPATIONAL THERAPISTS

81. Major shortages are present in mental, chronic, tuberculosis and other hospitals for such personnel - again, the supply is far from meeting the demand.

82. Bursaries are available for training.

83. The same remarks as above would apply also to other personnel, such as Vocational Counsellors, Medical Record Librarians, Hospital Administrators, Health Educators, Medical and Psychiatric Social Workers, Dietitians and others.

84. Some major step must be taken to increase such personnel if present requirements are to be met - increased health services would further increase the problem. Without sufficient numbers of such personnel any medical care plan will not be successful.

NURSING SERVICES

85. Nurses are required -

1. In hospitals of every type
2. For home nursing
3. In nursing homes and homes for the aged
4. In the Public Health Field
5. In industry
6. Teaching in hospitals and nursing schools.

86. In Nova Scotia, studies would indicate that



are required for hospitals, rehabilitation

But nurses are again available for training.

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chronic, tuberculosis and other hospitals for such personnel - again, the supply is far from meeting the

82. But nurses are available for training.

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1. In hospitals of every type

2. For home nursing

3. In nursing homes and homes for the aged

4. In the Public Health Field

5. In industry

6. Teaching in hospitals and nursing schools.

In Nova Scotia, studies would indicate that

1 we suffer from a definite shortage of nursing person-
2 nel. This shortage is most apparent in the hospital
3 and public health fields.

4 87. Even before the recent increase in hospital
5 beds there was a shortage of registered nurses. At
6 present, the shortage is acute - one major hospital is
7 reported to be short nearly 20 registered nurses.
8 The Department of Public Health in order to meet
9 modern standards, require about 75 additional Public
10 Health Nurses.

11 88. It is most difficult to obtain a registered
12 nurse for home nursing of a patient in many areas.
13 The presence of married nurses who return temporarily
14 to nursing duty serves to keep the situation from
15 becoming acute.

16 89. A factor which has helped the present
17 situation has been the development of Certified Nursing
18 Assistants who can carry out many of the duties of
19 a Registered Nurse. The Nursing Team concept has been
20 developed to a large extent - otherwise, many hos-
21 pital wards would be closed.

22 90. The acute and chronic mental hospitals also
23 reflect this major shortage - it has been impossible to
24 fill many staff shortages.

25 91. Many explanations have been given for the
26 Nurse shortage which is a continent wide situation and
27 not a Nova Scotia phenomenon.

28 92. 1. Low income during and after completion
29 of training

30 2. Marriage

and public health fields.

Even before the recent increase in hospital

beds there was a shortage of registered nurses. At

present, the shortage is acute - one major hospital is

reported to be short nearly 20 registered nurses.

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91. Many explanations have been given for the

Nurse shortage which is a continent wide situation and

not a Nova Scotia phenomenon.

1. Low income during and after completion

of training

2. Marriage

3. Movement of graduates to other parts of
 Canada and the United States.

4. Not enough Training Schools -- too few
 students

5. Outmoded methods of training nurses.

6. Overlong training period - 3 years

7. Not enough female High School graduates
 with entrance requirements

8. Too much discipline during training
 period

9. More new types of non hospital position
 now available which require a trained
 nurse background.

93. Whatever the reasons for the shortage, some
 action must be taken to improve the situation and
 increase the number of nursing personnel - with in-
 creasing numbers of hospital beds and other demands
 the situation will become more acute.

94. There are stated to be some 2,500 nurses
 in practice in the Province - there is a shortage of
 several hundred.

95. There are about 1,340 certified nursing assis-
 tants in the Province - again several hundred additional
 are said to be required.

96. SUGGESTIONS

1. Decrease training course to 2 years
 with paid "interne" year

2. Suitable subsidies during training
 period or a reasonable salary

3. Less technical and more practical training



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7. Not enough female High School graduates with entrance requirements
8. Too much discipline during training period
9. More new types of non hospital position now available which require a training

93. Whatever the reasons for the shortage, some action must be taken to improve the situation and increase the number of nursing personnel - with increasing numbers of hospital beds and other demands the situation will become more acute.

94. There are stated to be some 2,500 nurses in practice in the Province - there is a shortage of several hundred.

95. There are about 1,540 certified nursing assistants in the Province - again several hundred additional are said to be required.

1. Decrease training course to 2 years with paid "intern" year

3. Less technical and more practical training period or a reasonable salary



4. Increase income level of graduate to match at least that of other areas of Canada
5. Separate Training Schools from Hospitals
6. Use of trained O. R. Technicians to replace nurses in large hospitals
7. Increase number of Certified Nursing Assistants with more takeover of non technical nursing duties
8. Increased number of training schools or larger schools
9. More efficient use of training schools - specialized hospitals might close general training schools and provide more affiliate training
10. Increase training facilities for nursing assistants

97. "NURSING HOME" SERVICE

There is a major demand for "nursing home" service throughout the province. Many persons who are not eligible for general hospital admission require a type of "semi" hospital care, the main requirements being in most cases good nursing care, proper food and general supervision and assistance. Many of the patients are elderly and suffering from the results of age only, others have had cerebral accidents, fractures (especially of the hip), etc. In the past several years a considerable number of persons have



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1 have developed private homes into "nursing homes"
2 and looked after many patients - the trend became so
3 great that it was necessary to insure that such nursing
4 homes were not fire risks, gave proper nursing care and
5 in general were well operated.

6 98. In 1958 an Act was passed in the Legislature
7 providing for the licensing of Nursing Homes through-
8 out the Province, later Regulations were passed under
9 the Act in 1961 setting out the requirements of a
10 licensed Nursing Home.

11 99. To date few homes have been licensed but
12 many are taking the necessary steps to meet the re-
13 quirements - it is especially important that the fire
14 risk be reduced in such homes and this is causing
15 some difficulty.

16 100. It is difficult to determine just how many
17 nursing homes are operating throughout the province
18 but there are a substantial number.

19 101. It is felt that the development of licensed
20 Nursing Homes will help relieve the pressure on
21 general hospitals - many "hospital" patients can be
22 satisfactorily looked after in such homes at a smaller
23 cost - thus, general hospital beds can be available for
24 more urgent cases.

25
26 SERVICES IN THE HOME FOR CONVALESCENT, CHRONIC
27 ILL AND AGED
(Domiciliary Care)

28 102. It is increasingly clear that it is not
29 possible either physically or financially to build and
30 staff hospital beds for all the ill persons in the



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SERVICES IN THE HOME FOR CONVALESCENT, CHRONIC ILL AND AGED

102. It is increasingly clear that it is not possible either physically or financially to build and staff hospitals beds for all the ill persons in the



1 province. Further, many ill persons are more com-
2 fortable and satisfied in their own homes.

3 103. Unfortunately, the advent of small homes and
4 larger families has made this more difficult, never-
5 theless, much can be accomplished in home care of the
6 ill if certain assistance is provided, the major
7 requirement being nursing assistance and advice and
8 housekeeping assistance.

9 104. In this province the Victorian Order of
10 Nurses operate an efficient Home Visit Nursing Service
11 in many areas - their work is greatly appreciated. It
12 has been suggested that a major increase in this type
13 of service would be of great value to patients, to
14 their families and to the hospital situation.

15 105. In some areas of Canada, such Visiting Nurse
16 Service is operated in cooperation with a hospital -
17 patients get home earlier - are more comfortable at
18 home, the family is together again and the cost of
19 hospitalization is reduced, and a bed is made avail-
20 able for another patient in the hospital. Several
21 experimental projects are in operation in Canada with
22 apparent good results. On a small scale such a
23 scheme is offered at the Victoria General Hospital in
24 cooperation with the Victorian Order of Nurses.

25 106. Further, it has been suggested that the
26 Provincial Public Health Nurses should be part of such
27 a system and offer bedside nursing throughout the
28 province. This suggestion has been under consideration
29 - an acute shortage of Public Health Nurses has been a
30 difficulty - at present the Department is short some



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Larger families have made this more difficult, nevertheless, much can be accomplished in home care of the ill if certain assistance is provided, the major requirement being nursing assistance and advice and

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105. In some areas of Canada, such as the Home Visit Nursing Service is operated in cooperation with a hospital - patients get home earlier - are more comfortable at home, the family is together again and the cost of hospitalization is reduced, and a bed is made available for another patient in the hospital. Several experimental projects are in operation in Canada with apparent good results. On a small scale such a scheme is offered at the Victoria General Hospital in cooperation with the Victorian Order of Nurses.

106. Further, it has been suggested that the Provincial Public Health Nurses should be part of such a system and other bedside nursing throughout the province. This suggestion has been under consideration - an acute shortage of Public Health Nurses has been a difficulty - at present the Department is short of



1 75 nurses to meet modern standards.

2 107. A recent trial of employing Certified
3 Nursing Assistants to work with Public Health Nurses
4 would appear to be very worth-while; such a combined
5 team might enable the Department to provide a visit-
6 ing nursing service, particularly in the rural areas.

7 "Homemakers" - Housekeepers

8 108. It has been found that looking after an
9 ill person in the home takes up the greater part of
10 he time of the wife or mother - loss of sleep makes her
11 less efficient - the care and feeding of the family
12 suffers. In such cases in several countries this
13 situation is recognized and dealt with by the pro-
14 vision of "homemakers" or housekeepers - often at
15 public expense. In this way the family is kept
16 together, the patient is kept out of hospital, the
17 home and family are looked after, the wife or mother
18 is left free to deal with the patient, she is not
19 exhausted by doing double duty.

20 109. In this province the Red Cross Society
21 operate such a service in a few areas - the service
22 is charged for at a nominal rate and is well received.

23 110. It has been suggested that the setting up of
24 a Visiting Nurse Service together with a "homemaker"
25 service would do much to help relieve the hospital
26 bed situation.

[illegible]

REPORT ON STATUS (1961) OF
 FACILITIES AND SERVICES IN PUBLIC HOSPITALS, ASSOCIATED
 TRAINING SCHOOLS AND RELATED HEALTH FACILITIES

Source: Nova Scotia Hospital Insurance Commission

111. This report is necessarily brief, but reasonably comprehensive. Having in mind the breadth of the subject matter and the relatively short time allowed for its preparation, it does not pretend to cover anything else but the main points, and these on a Provincial basis; detailed information at the regional or hospital level is available if required.

112. It is understood that the Provincial Brief is to be divided into Part I - dealing with the present status, and Part II - dealing with future requirements. Only Part I is to be presented now. Later, Part II will be presented, and that part will include specific recommendations.

I HOSPITAL BEDS

1. Hospital Regions

113. Nova Scotia divides itself naturally into nine (9) hospital regions, which are reasonably distinct entities as far as hospital care is concerned.

114. Diagrammatically for planning, each region has a central regional hospital and peripheral local hospitals.

115. The local hospitals have the limited facilities and provide the limited services of the traditional

TRAINING SCHOOLS AND RELATED HEALTH FACILITIES

Source: Nova Scotia Hospital In-
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reasonably comprehensive. Having in mind the breadth

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115. The local hospitals have the limited facilities

and provide the limited services of the local level.



1 small community general hospital.

2 116. The regional hospital has more elaborate
3 facilities and provides more specialized services:
4 (a) there are such facilities as a Long Stay Re-
5 activation Unit (some 20 beds), a physiotherapy
6 department, a comprehensive lab (histology, bio-
7 chemistry, haematology and bacteriology), a 2 unit
8 x-ray department (diagnostic and fluoroscopic), a
9 community (public health) section, intensive care
10 unit, a nurses training school, a training school for
11 lab and x-ray technicians, etc.; and (b) there are
12 such services as provided by a physiotherapist, a
13 pathologist ($\frac{1}{2}$ time or more), a radiologist ($\frac{1}{2}$ time
14 or more, etc. In summary, the regional hospital
15 is equipped and staffed to take care of the more
16 difficult diagnostic and treatment problems referred
17 by the local hospital.

18 117. In Halifax, the capital and the site of the
19 only medical school in the Atlantic Provinces, there
20 are situated the referral hospitals. These several
21 hospitals (e.g. Victoria General, Children's Hospital)
22 are equipped and staffed to handle the most difficult
23 diagnostic and treatment problems (metabolic, cardiac,
24 neurosurgical, tumor cases, etc.) referred by the
25 regional or local hospitals. Only the rare patient,
26 as a septal defect, need be referred outside Nova
27 Scotia because the services are not available in the
28 province.

29 2. Number, Type and Bed Capacity of Hospitals
30 in Nova Scotia.

16. The regional hospital has more elaborate facilities and provides more specialized services: (a) there are such facilities as a Long Stay Re-activation Unit (some 20 beds), a physiotherapy department, a comprehensive lab (histology, pro-chemistry, haematology and bacteriology), a 2 unit x-ray department (diagnostic and fluoroscopic), a community (public health) section, intensive care unit, a nurses training school, a training school for lab and x-ray technicians, etc.; and (b) there are such services as provided by a physiotherapist, a pathologist ($\frac{1}{2}$ time or more), a radiologist ($\frac{1}{2}$ time or more), etc. In summary, the regional hospital is equipped and staffed to take care of the more difficult diagnostic and treatment problems referred by the local hospital.

17. In Halifax, the capital and the site of the only medical school in the Atlantic Provinces, there we situated the referral hospitals. These several hospitals (e.g. Victoria General, Children's Hospital) are equipped and staffed to handle the most difficult diagnostic and treatment problems (metabolic, cardiac, neurosurgical, tumor cases, etc.) referred by the regional or local hospitals. Only the rare patient, as a septal defect, need be referred outside Nova Scotia because the services are not available in this



A. Number

118. There are 47 public hospitals and 1 DVA Hospital; all of which participate under the Hospital Insurance Plan. In addition, 2 facilities, the Dartmouth Medical Centre (Diagnostic X-ray only) and the Red Cross Blood Transfusion Depot, participate under the Plan.

B. Type

119. Of the 47 public hospitals, 3 are specialized: Grace Maternity (74 beds); the Children's Hospital (196 beds) and the Nova Scotia Rehabilitation Centre (20 beds).

120. The following is an analysis of the public hospitals by capacity:

C. Capacity

<u>Capacity</u>	<u>Number of Hospitals</u>
0 - 24	15
25 - 49	13
50 - 99	9
100 - 199	6
200 - 299	3
500 plus	1

121. The total capacity of all Public Hospitals is 3,401 beds. This provides approximately 4.7 beds per 1,000 population. However, on a regional basis, there is a range of approximately 2.1 to 8.4.

122. There are some 20 bed long stay "units" in each of Sydney City Hospital, St. Martin's, St. Rita's and the Aberdeen Hospital - all outside the Atlantic Region. In addition, there are in the



In addition, 2 facilities, the
Medical Centre (Diagnostic X-ray only) and
the Red Cross Blood Transfusion Dept., participate
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II. Type

On the 47 public hospitals, 3 are specialized:
Grace Maternity (74 beds); the Children's Hospital
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The following is an estimate of the public
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Capacity	Number of Hospitals
0 - 24	15
25 - 49	25
50 - 99	9
100 - 199	6
200 - 299	3

151. The total capacity of all Public Hospitals
is 3,401 beds. This provides approximately 4.7 beds
per 1,000 population. However, on a regional basis,
there is a range of approximately 2.1 to 8.4.

152. There are some 20 bed long stay "nurses" in

Atlantic Region. In addition, there are in the
Riviera and the Aberdeen Hospital - all outside the



Atlantic Region (actually Halifax City) 20 beds at the Nova Scotia Rehabilitation Centre, and 54 beds at the Halifax Convalescent Hospital. Therefore, the total of 3,401 beds can be broken down into 3,247 active treatment beds (4.45 per 1,000 population) and 154 long stay beds (0.25 per 1,000 population.)

3. New Construction

123. The actual or firmly anticipated construction of new hospital beds and facilities is pertinent and important to the present status of hospitals.

A. Additional Beds to be Added in 1961

Hospital	Total Beds constructed	Previous Capacity	Net Increase in Capacity Active	Long Stay	Total
Soldiers' Memorial	68	23	45	-	45
Yarmouth General	163	41	92	30	122
Halifax Infirmary	341	192	290	-	290
Total	572	256	427	30	457

124. This means that by approximately the end of 1961, the total bed capacity of public hospitals will be 3,853 or 5.3 per 1,000 population.

125. B. Additional Beds now under Construction and to be Completed by Approximately the End of 1962

Hospital	Total Beds Constructed	Previous Capacity	Net Increase in Capacity Active	Long Stay	Total
New Waterford	88	38	50	-	50
Grace Maternity	111	74	37	-	37
Total	199	112	87	-	37



3,247 active treatment beds (4.45 per 1,000 popula-
tion) and 154 long stay beds (0.22 per 1,000 popula-

123. The annual or firmly anticipated construction
of new hospital beds and facilities is pertinent and
important to the present status of hospitals.
A. Additional Beds to be Added in 1961

Hospital	Contracted	Previous Net Increase in Capacity	Active Long Stay	Total
Soldiers'	68	23	45	48
Yarmouth General	103	41	92	182
Helthix	241	122	220	290
Total	212	286	457	487

124. This means that by approximately the end of
1961, the total bed capacity of public hospitals will be
3,823 or 5.3 per 1,000 population

125. B. Additional Beds now under Construction and
to be Completed by Approximately the End of
1964

Hospital	Contracted	Previous Net Increase in Capacity	Active Long Stay	Total
New Waver-	88	38	50	70
ford	111	50	100	151
Total	199	112	150	261



126. This means that during 1962, an additional 87 beds should be added, to give the province a grand total of 3,945 beds (5.4 per 1,000 population).

C. Additional Beds Approved, but no Construction Started

127. The Commission has approved, at least in principle construction in respect of 19 individual hospitals. This will provide a net increase in capacity totalling 912 beds; of these 793 are active treatment, and 119 are long-stay.

4. Patient Days per 1,000 Population

128. In 1960, the latest year for which figures are available, the patient days (adults, children and newborn - insured and uninsured) per 1,000 population (total) were 1621.

5. Hospital Discharges per 1,000 population

129. In 1960, there were 175 discharges (adults, children and newborn - insured and uninsured) per 1,000 population (total).

6. Average Stay in Days

130. In 1960, the average stay for adults and children was 9.84 days; for newborn it was 6.2. Here, again, the figures apply to insured plus uninsured.

II DIAGNOSTIC SERVICES

131. For the sake of brevity, and because of their very major significance, this section will deal essentially with laboratory and radiological services.

132. In passing, it may be said that practically all hospitals have electrocardiographic machines, and



Grand total of 3,945 beds (2.4 per 1,000 population).

C. Additional Beds Approved, but no Construction Started

127. The Commission has approved, at least in principle construction in respect of 12 individual hospitals. This will provide a net increase in capacity totaling 912 beds; of these 793 are active treatment, and 119 are long-stay.

4. Patient Days per 1,000 Population
128. In 1960, the latest year for which figures are available, the patient days (adults, children and newborn - insured and uninsured) per 1,000 population (total) were 152.1.

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essentially with laboratory and radiological ser-

132. In passing, it may be said that practically all hospitals have electrocardiographic machines, and

that electroencephalography is carried out only at two of the referral hospitals, the Victoria General and the Children's Hospital.

1. Laboratory Services

133. A. Facilities

There are regional type laboratories in 9 (two adjacent regional type hospitals, counted as one above, together provide all the range of services, and share a pathologist) regional or referral hospitals; i.e., these hospitals are built, equipped and staffed to provide histological, biochemical, bacteriological and haematological services.

134. The Victoria General, Grace Maternity, Nova Scotia Rehabilitation Centre and Halifax Convalescent Hospital use the facilities of the Central Laboratories (Department of Public Health) for all but simple routine tests.

135. Local hospitals have laboratories with general facilities and equipment commensurate with their size.

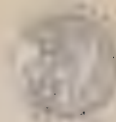
136. As stated above, the Red Cross Blood Transfusion Depot (Halifax) is a facility.

137. With the rapid increase in the complexity and extent of laboratory services, it is very evident that very generally laboratory facilities, in respect of actual space, are inadequate.

138. Equipment generally is reasonably satisfactory.

139. B. Services

As indicated above, local hospitals provide



two of the referral hospitals, the Victoria General and

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(two adjacent regional type hospitals, counted as one
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and extent of laboratory services, it is very evident
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As indicated above, local hospitals provide



only the more simple and basic tests; the more complex tests and all bacteriology are referred to regional or referral hospitals, or to the Central Labs.

140. Regional and referral hospitals (excepting the Victoria General) provide practically the complete spectrum of laboratory services.

141. Blood banks are located strategically, generally in regional hospitals. The central bank is the Red Cross Blood Transfusion Depot in Halifax.

142. It is estimated that in 1961, clinical laboratories of public hospitals will have the following workload:

Classification	Hospital <u>In-Patients</u>	Hospital <u>Out-Patients</u>	Referred <u>In</u>	<u>Total</u>
Haematology	376,584	107,904	9,540	494,028
Biochemistry	469,728	105,936	24,384	600,048
Bacteriology	132,684	22,380	24,612	179,676
Histology	99,216	13,716	19,512	132,444
Other (Blood Bank, Serology, Misc.)	91,536	24,192	7,848	123,576
Total	1,169,748	274,128	85,896	1,529,772
Plus Milk and Water (2 hospitals)				27,108
Grand Total				1,556,880

143. C. Staff

As of September, 1961, there were on the staff of public hospitals 44 registered technicians, 4 combined technicians (trained in lab and x-ray - Newfoundland Short Course), 63 non-registered "technicians", one biochemist and 9 pathologists.



on referral hospitals, or to the Central Labs.

140. Regional and referral hospitals (excepting

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141. Blood banks are located strategically.

Generally in regional hospitals. The central bank

is the Red Cross Blood Transfusion Depot in Halifax.

142. It is estimated that in 1961, clinical

laboratories of public hospitals will have the follow-

ing workload:

Classification	Hospital	In-laboratory out-laboratory	Referrals in	Total
Hematology	376,584	107,204	7,240	491,028
Biochemistry	469,728	107,204	24,724	601,656
Histology	92,216	13,716	13,716	119,648
Other (Blood	91,536	24,192	7,848	123,576
Misc.)				
Total	1,169,748	244,128	52,828	1,466,704

Time Milk and Water (2

Grand Total 1,500,880

In October, 1961, there were on the

staff of public hospitals 44 registered technicians.

4 combined technicians (trained) in lab and x-ray.

"technicians", one biochemist and 2 pathologists.

144. There is a definite shortage of registered technicians - 20 could be placed immediately. At this time, 3 local hospitals are without any technicians.

D. Training of Staff

145. Trainees take a 16 month course (12 months in a public hospital and 4 months in the Central Labs), leading to registration. Financial assistance is provided by the Commission at the rate of \$100 per month plus allowance for travel and books.

146. As of October 15, 1961, 30 students had started their course (September 1, 1961) and 25 students were nearing the completion of their course (December 31, 1961). Training was being carried out in 7 regional or referral hospitals.

147. Because of the lack of applications, the number of trainees is significantly inadequate.

2. Radiological Services

A. Facilities

148. Of the 47 public hospitals, 46 have x-ray equipment. The only one without such equipment is a 9 bed outpost type of hospital.

149. Of the 46 with x-ray equipment, 20 hospitals do not have fluoroscopic equipment. These are the hospitals that do not have the regular services of a radiologist.

B. Services

150. Local hospitals without a regular radiologist provide the more basic and simple diagnostic x-ray services. They have generally a mail-order arrangement

At this time, 3 local hospitals are without any chest-
X-ray - 20 could be placed immediately. At

D. Training of Staff

Trainees take a 10 month course (12 months in a public hospital and 4 months in the Central Labs) leading to registration. Financial assistance is provided by the Government at the rate of \$100 per month plus allowance for travel and books.

As of October 15, 1961, 30 students had started their course (September 1, 1961, and 25 students were nearing the completion of their course (December 31, 1961). Training was being carried out in 7 regional or referral hospitals.

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A. Facilities

Of the 14 public hospitals, 46 have X-ray equipment. The only one without such equipment is a 9 bed outpost type of hospital.

Of the 40 with X-ray equipment, 20 hospitals do not have fluoroscopic equipment. These are the hospitals that do not have the regular services of a radiologist.

Local hospitals without a regular radiologist provide the more basic and simple diagnostic X-ray services. They have generally a well-ordered arrangement.



1 with the nearest radiologist.

2 151. Regional hospitals, and those local hos-
3 pitals with a regularly attending radiologist, provide
4 diagnostic and fluoroscopic (G.I. Series, etc.)
5 services.

6 152. The referral hospitals as a group provide
7 the most complex diagnostic services (e.g., angiora-
8 diography) as well as radioactive isotopes, radium,
9 cobalt-beam therapy, etc. Without going into detail,
10 it may be said that, radiotherapy in general is
11 channeled through the Nova Scotia Tumor Clinic which is
12 a part of the Victoria General Hospital.

13 153. Public Hospitals and the Dartmouth Medical
14 Centre (a facility), in respect of diagnostic radio-
15 logical services, will have a 1961 total workload of
16 338,000 in-patient Rm units; 543,000 out-patients
17 Rm units and a grand total of 881,000 Rm units.
18 (It is to be noted that the average x-ray examina-
19 tion is equivalent to 3.39 Rm units).

20 C. Staff

21 154. During 1961, there were on the staff of
22 public hospitals 88 registered x-ray technicians,
23 4 combined technicians (trained in lab and x-ray -
24 Newfoundland Short Course), 15 non-registered
25 "technicians", and 23 radiologists. Three other
26 radiologists, not attached primarily to public hos-
27 pitals, also provide interpretive services to a few
28 local hospitals.

29 155. There are an adequate number of technicians.
30 There is a significant shortage of radiologists.



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152. The referral hospitals as a group provide the most complex diagnostic services (e.g., angiography) as well as radioactive isotopes, radium, and other radioactive materials.

153. It may be said that, radiotherapy, in general is channelled through the Nova Scotia Tumor Clinic which is a part of the Victoria General Hospital.

154. Public Hospitals and the Dartmouth Medical Centre (a facility), in respect of diagnostic radiological services, will have a 1961 total workload of 338,000 in-patient RM units; 843,000 out-patients RM units and a grand total of 881,000 RM units.

(It is to be noted that the average x-ray examination is equivalent to 3.32 RM units).

155. During 1961, there were on the staff of

4 combined technicians (trained in lab and x-ray -

"technicians", and 23 radiologists. Three other radiologists, not attached primarily to public hospitals, also provide interpretive services to a few

156. There are an adequate number of radiologists. There is a significant shortage of radiologists.



D. Training of Staff

156. Trainees take a 24 month course leading to registration. Financial assistance is provided by the Commission at the rate of \$100 per month plus allowance for travel and books.

157. As of October 15, 1961, 18 students were in the first year of the course, and 42 were in the second year. Training is being carried out in 8 regional or referral hospitals.

158. There is a surplus of applications for training in x-ray technology.

159. III NURSING SERVICES

1. Residence and Training School Facilities

A. Present Status

(1) Residences

At this time there are 13 regional or referral hospitals with schools of nursing. In connection with these schools, there are 1424 residence beds, of which 392 are obsolete. In the instance of two hospitals there is a lack of 38 and 53 residence beds, for a total of 91.

160. From the above it is evident that at this time there is required some 400 nurses beds to replace beds that are obsolescent or totally lacking.

(2) Classrooms etc.

161. Suffice it to say that classroom and teaching space is inadequate in many instances. In a number of schools, there are no facilities for teaching the basic services.



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 regional or referral hospitals.

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 training in x-ray technology.

159. III. NURSING SERVICES

1. Residence and Training School Facilities

A. Present Status

(1) Residences

At this time there are 13 regional or

referral hospitals with schools of nursing. In

connection with these schools, there are 124 beds.

of which 302 are obsolete. In the last

of two hospitals there is a lack of 30 and 37 beds.

of 21 beds, for a total of 91.

160. From the above it is evident that at this

time there is required some 400 nurse beds to replace

beds that are obsolete or totally lacking.

(2) Classrooms etc.

161. Sufficient to say that classrooms and

a number of schools, there are no less than 100

B. New Construction

162. During 1961, there were added 24 nursing beds at the Halifax Infirmary, and 28 at the Fishermen's Memorial; these 52 beds were all for graduate nurses.

163. In 1962, more beds will be added:

New Waterford 45 (14 student CNA's and 31 graduates)

Queens 27 (all graduates)

Grace Maternity 16

164. Therefore, by 1962 there should be a considerable improvement in the situation.

165. Moreover, the Commission has approved plans for new nurses residences and training school facilities at St. Rita and St. Martha's Hospitals to replace existing obsolete buildings. St. Martha's will have 135 beds (120 for students); and St. Rita will have 100 beds (89 students).

166. It is now the policy of the Commission that, in future, nurses residence beds will only be approved for student nurses or student nursing assistants, in connection with hospitals with schools of nursing.

2. Nursing Staff

A. Types of Nursing Personnel

167. In simple terms it may be said that Nursing Services are provided by two main types of personnel:

(1) Professional

168. This group includes all those who have completed a three year course in nursing at a recognized school. The students taking a three year



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recognized school. The students taking a three year



1 course in nursing at a recognized school are also
2 considered as part of the professional group.

3 (2) Non-professional

4 169. This group includes all those who have
5 become certified as nursing assistants, as well as
6 on-the-job trained personnel.

7 B. Standards for Estimating Nursing Staff
8 Requirements

9 170. It has been estimated following various
10 studies in nursing, that the average necessary amount
11 of nursing service per patient is 3.4 hours per day.
12 This figure takes into account only those giving bed-
13 side care and excludes such personnel as head nurses
14 and supervisors and personnel in such areas as
15 Operating Rooms, Central Supply and Out-Patients.

16 171. It is considered that each student nurse
17 will provide 1/3 of the service of a graduate nurse.
18 The primary objective for students is learning but as
19 learning takes place, service is also given.

20 172. In active treatment units it is assumed that
21 the overall ratio between professional nurses (in-
22 cluding general duty nurses, head nurses and super-
23 visors) and non-professional staff should be about
24 60 per cent professional to 40 per cent non-profes-
25 sional. In long stay units the ratio should be one pro-
26 fessional nurse to three non-professional staff.

27 C. Nursing Personnel Now Employed
28 by Hospitals

29 173. (1) Graduate Nurses 1813

30 (2) Student Nurses 1242



course in nursing at a recognized school are also considered as part of the professional group.

(2) Non-professional

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B. Standards for Estimating Nursing Staff Requirements

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172. In active treatment units it is assumed that including general duty nurses, head nurses and supervisors (and non-professional staff) should be about 60 per cent professional to 40 per cent non-professional. In long stay units the ratio should be one professional nurse to three non-professional staff.

C. Nursing Personnel Now Employed

by Hospitals

173. (1) Graduate Nurses 1818



(3) Certified Nursing Assistants 368

(4) On-the-job Trained Personnel 275

Total 3698

174. Without going into detail, it may be said that at this time, on a total provincial basis, there are an adequate number of total nursing personnel to provide nursing services in general hospitals. However, in a number of specific hospital areas there is a significant shortage of nurses.

3. Training of Nursing Personnel

A. Certified Nursing Assistants

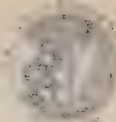
175. There are now two schools for nursing assistants in general hospitals, one at St. Martha's Hospital and the other at the Halifax Infirmary. The New Waterford General Hospital is planning to open a school. Several government hospitals and the Maritime Technical Institute, Moncton, train Nursing Assistants. In general hospitals this course has been for females but there does appear to be a need for trained male staff.

B. Student Nurses

176. In Nova Scotia there are thirteen public hospitals conducting schools of nursing in the three year basic program. One of these hospitals is a paediatric hospital and one an obstretical hospital. Three regional hospitals plan to start schools of nursing when present facilities are expanded.

C. Teaching Staff

177. One of the most serious defects in the nursing education program is the shortage of qualified



(4) On-the-job Trained Personnel 275

3629

Total

174. Without going into detail, it may be said that at this time, on a total provincial basis, there are an adequate number of total nursing personnel to provide nursing services in general hospitals. However, in a number of specific hospital areas there is a significant shortage of nurses.

3. Training of Nursing Personnel

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C. Teaching Staff

177. One of the most serious defects in the nursing education program is the shortage of qualified



1 Directors of Schools as well as qualified teaching
2 and supervisory personnel. In 1961 there were 59
3 instructors and of this number 40 have one year uni-
4 versity training or better. We presently require
5 about 100 instructors so that we have only 40 per
6 cent of number required at present. With three new
7 nursing schools an additional 15 instructors will
8 be required giving an overall shortage of 75
9 qualified instructors.

10 D. Standard of Nursing Education

11 178. At present the standard of nursing
12 education presents a serious problem. There has been
13 a failure rate of over 40 per cent in registration
14 examinations written in 1960 by student nurses in this
15 province. Students from more than fifty provinces
16 and states write the same examinations and students
17 from this province ranked the lowest.

18 179. A school improvement program has been
19 started by the Canadian Nurses Association to help raise
20 standards in schools of nursing.

21 IV HOSPITAL PERSONNEL - OTHER

22 180. In this section, reference will be made
23 only to certain main categories.

24 1. Dietitians

25 181 In 1961, there were 33 full-time and 1 part
26 time dietitian on the staffs of public hospitals;
27 this is an increase of 10 over 1958.

28 182. There is a real but not severe shortag
29 of qualified dietitians.
30

Directors of Schools as well as qualified teachers

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about 100 instructors so that we have only 40 per

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standards in schools of nursing.

IV HOSPITAL PERSONNEL - CHIEF

180. To this section, reference will be made

only to certain main categories.

1. Dietitians

181. In 1961, there were 35 full-time and 1 part

time dietitians on the staffs of public hospitals.

this is an increase of 10 over 1958.

182. There is a real but not severe shortage

183. Training facilities are available and of good calibre in this province. The basic training can be taken at a number of universities in Nova Scotia; two of our referral hospitals operate approved schools for dietetic interns.

184. The problem is firstly to interest a girl to take the training, and secondly, to retain her in hospital work in this province. Industry is absorbing a number of dietitians. The high salary rates in the States and in certain Provinces are attractive. Moreover, matrimony takes its annual toll.

2. Medical Social Workers

185. In 1961, there were only 6 workers, employed by 2 hospitals: Children's (2) and the Victoria General (4).

186. Regional and referral hospitals are encouraged to employ medical social workers.

187. Training facilities are all available in the province. It would seem that to date, other fields have attracted the attention of graduates.

3. Physiotherapists and Occupational Therapists

188. In 1961, public hospitals employed 17½ PTs and 4 OTs; in 1958 there were 11 PTs and 3 OTs.

189. There is a very real and indeed severe lack of these personnel. Suffice it to say that outside the City of Halifax, there are only 2 PTs and no OTs. It is part of the overall plan for an integrated and coordinated system of hospitals, that such services should be available in regional hospitals.



Scotland; two of our referral hospitals operate approved

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186. Regional and referral hospitals are en-

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187. Training facilities are all available in

the province. It would seem that to date, other

fields have attracted the attention of graduates.

188. In 1951, public hospitals employed 17½ MAs

and 4 OTs; in 1952 there were 11 MAs and 3 OTs.

189. There is a very real and urgent need for more

of these personnel. Besides it to say that outside

the City of Halifax, there are only 2 MAs and no

OTs. It is part of the overall plan for an inte-

grated and co-ordinated system of hospitals, that such

services should be available in regional hospitals.



1 190. Training facilities are not now available
2 in Nova Scotia. However, it seems likely that in
3 the not too distant future there will be a school at
4 Dalhousie.

5 191. With a school in the province, it is likely
6 that the present shortage will diminish appreciably.
7 Of course, there is a continent wide shortage of such
8 people.

9 4. Pharamacists

10 192. In the modern active treatment hospital, the
11 pharmacy is the most intensively used therapeutic
12 facility in the institution. With the availability of
13 a greater number and more efficient agents used for
14 the prevention, diagnosis, treatment or rehabilitation,
15 the pharmacist has been accepted as an equal partner
16 with other hospital staff members in the care of
17 patients.

18 193. In 1961, public hospitals employed 14 full
19 time pharmacists; this compares with 7 in 1958. Even
20 so, 31 of 47 hospitals were without the services of a
21 pharmacist.

22 194. The shortage of pharmacists at this time,
23 is significant, although not acute.

24 195. A new faculty has been created at Dalhousie
25 University which includes the College of Pharmacy,
26 and a new 4 year course based on junior matriculation
27 has been introduced. In 1960-61, 51 students were
28 enrolled; in 1961-62, enrolment has risen to 78. It
29 is considered that the enrolment should reach 110,
30 in order to provide for the needs of the Atlantic



With a school in the province, it is likely that the present shortage will diminish appreciably. Of course, there is a continent wide shortage of such people.

192. In the modern active treatment hospital, the pharmacy is the most intensively used therapeutic facility in the institution. With the availability of a greater number and more efficient agents used for the prevention, diagnosis, treatment or rehabilitation, the pharmacist has been accepted as an equal partner with other hospital staff members in the care of

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University which includes the College of Pharmacy, and a new 4 year course based on junior medical education has been introduced. In 1960-61, 51 students were enrolled; in 1961-62, enrollment has risen to 63. It is considered that the enrollment should reach 110.



1 Provinces.

2 196. It is estimated that for 1961, the total
3 cost to the Commission for drugs, medical and surgical
4 supplies, will be \$1,930,000 (\$1.82 per patient day).

5
6 V HOSPITAL INSURANCE PLAN

7 1. Administration

8 197. Administration by a 5-7 man commission
9 responsible to the minister of Public Health, has
10 proved satisfactory. There are two important factors
11 contributing to this: (1) the Hospital Insurance Act
12 makes it mandatory that 2 members are hospital trus-
13 tees or administrative officials, and that 1 member
14 is a member of the Provincial Medical Society in
15 good standing - this assures the professional
16 viewpoint; (2) regulations can only be made by the
17 Governor in Council (not the Commission) - this
18 leaves proper control with Government.

19 2. Insured Services

20 198. This province provides an unusually large
21 number of out-patient services.

22 199. The philosophy of the Commission has been,
23 (a), to insure those out-patient services which if not
24 insured, would likely result in the patient being
25 admitted as an in-patient, and (b) not to insure
26 those out-patient procedures that ordinarily could
27 be done in the doctor's office.

28 200. The implementation of this philosophy has
29 proved most practical and efficacious. Prior to the
30 start of the plan on January 1st, 1959, responsible
people were asserting that hospitals would be



cost to the Commission for drugs, medical and surgical

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(a), to insure those out-patient services which it has

insured, would likely result in the patient being

admitted as an in-patient, and (b) not to insure

those out-patient procedures that ordinarily could

be done in the doctor's office.

200. The implementation of this philosophy has

proved most practical and efficacious. From 1940 to

1949 the plan on January 1st, 1949, responsible

were asserting that hospitals could be



1 overwhelmed and there would be "chaos", because of
2 the lack of beds. By the middle of 1961, 2½ years
3 after the plan had been in operation, there was still
4 no appreciable increase in beds and still no "chaos"
5 - this, it is felt, was due to the large range of
6 insured out-patient services.

7 201. Briefly, it may be said that at this time,
8 the following are the insured out-patient services.

- 9 (1) Almost all laboratory tests.
- 10 (2) Electroencephalograms
- 11 (3) Use of radioactive isotopes for diagnosis
- 12 (4) Radiotherapy for malignancy
- 13 (5) Physiotherapy
- 14 (6) Nursing Services
- 15 (7) All diagnostic radiological procedures
- 16 (8) Practically all hospital services, including
17 drugs, for the emergency diagnosis and
18 treatment within 48 hours of an accident
- 19 (9) Services, other than medical services, of
20 the Nova Scotia Tumor Clinic
- 21 (10) Blood and therapeutic blood protein fractions
- 22 (11) Hospital services in connection with 20
23 classes of minor medical and surgical pro-
24 cedures - this is quite comprehensive and
25 adequate.

26 3. Control of Standards and Utilization

27 202. This province "broke new ground" in for-
28 mally establishing control primarily and basically
29 at the "grass-roots" level of the hospital.
30



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202. This provides "quite new ground" in for-
 mally establishing control primarily and basically
 at the "grass-roots" level of the hospital.



203. Under the Regulations, each hospital has a hospital standards committee composed of at least the administrator, a board representative and a medical staff member. This committee meets semi-monthly reviews admissions length of patient stay, drug usage, diagnostic services, extra nursing services, etc., and advises the board if in its opinion the standard of any service is unsatisfactory or the utilization of any service provided by the hospital is not reasonable and proper.

204. The medical member(s) of the Standards Committee, with such other members of the medical staff as are appointed by that staff, constitute a medical subcommittee whose function is to study matters primarily of a medical nature, and to report to and advise the Hospital Standards Committee.

205. Here again, prior to and after the start of the plan, it was said by competent individuals that this was too Utopian and wouldn't work. In point of fact, hospital boards, administrators and medical staffs have accepted generally both the authority and responsibility. After almost 3 years of operation, this part of the plan functions more smoothly and effectively than we ever hoped. It is noteworthy that this type of standards control has been and is being adopted in other jurisdictions.

4. Costs

206. The following is the estimated cost of operation in 1961:



Under the legislation, each hospital has a
official standards committee composed of at least the

This committee meets semi-monthly
reviews admissions length of patient stay, drug usage,

and advises the board in its opinion the standard
of any service is unsatisfactory or the utilization
of any service provided by the hospital is not reason-
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mittee, with such other members of the medical staff
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hospital boards, administrators and medical staffs have
accepted generally from the authority and responsi-

bility. After almost 3 years of operation, this part

of the plan has been accepted and the hospital is

now in a position to

the hospital is now in a position to



(1)	Payments to hospitals in Nova Scotia	
(a)	Federal Hospitals	\$ 810,000
(b)	Public Hospitals	<u>23,050,000</u>
	Subtotal (a) plus (b)	23,860,000
(2)	Payments to hospitals outside Nova Scotia	200,000
	Subtotal (1) and (2)	24,060,000
(3)	Administration Expense	289,550
(4)	Less Third Party Recoveries	<u>50,000</u>
	Grand Total	24,299,550
(5)	Government of Canada Share	12,992,400
(6)	<u>Net Cost to Province</u>	<u>\$11,307,150</u>

VI CONCLUSION

207. In line with the policy of the Government of Nova Scotia in respect of the brief of the Province, an attempt has been made to present a necessarily brief but accurate summary of the present status. At a later date, Part II, dealing with forecasts to 1970 and making general and specific recommendations, will be forwarded.

PROVISION OF DRUGS AND BIOLOGICALS

208. The above are necessary for the prevention and treatment of many medical conditions.

209. In general, it is now the responsibility of the citizen to obtain and pay for such drugs as are required.

210. "Proprietary" Drugs and medicines are obtained for a price from drug stores, etc. - a large expenditure is made on a self medication basis - results are



(1) Payments to hospitals in Nova Scotia
 (a) Federal Hospitals \$ 810,000
 (b) Public Hospitals 23,000,000

(2) Payments to hospitals outside Nova Scotia 200,000
 Subtotal (1) and (2) 24,000,000
 (3) Administration Expenses 282,550
 (4) Less Third Party Recoveries - 50,000
 Grand Total 24,802,550
 (5) Government of Canada Share 12,902,400
 (6) Net Cost to Province \$11,900,150

VI. CONCLUSION

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1 difficult to assess.

2 211. "Prescription" drugs are obtained from drug
3 stores based on an order from a physician - a charge
4 is usually made by the druggist over and above the cost
5 of the drug.

6 212. In all general hospitals, all necessary drugs
7 ordered by the physician are covered by the Hospital
8 Insurance Plan.

9 213. Biologicals for prevention of communicable
10 diseases are available from the Department of Public
11 Health on a free basis - provided the physician
12 provides the service on a free or reduced charge basis.

13 214. Such drugs are also provided free for public
14 clinics - examples are polio vaccine, smallpox vaccine,
15 quadruple antigen, etc.

16 215. On a means test basis, the Government also
17 provides insulin, anti-diabetic drugs and test mater-
18 ials to those suffering from diabetes mellitus.

19 216. The Government also provides free penicillin
20 for the treatment of venereal disease.

21 217. Free drugs are also provided by the Govern-
22 ment for treatment of tuberculosis, both in and out of
23 sanatoria.

24 218. Tranquillizing drugs are provided by the
25 Government for use in mental hospitals.

26 219. "Special Drugs" - some of the newer drugs are
27 very expensive - some of these are essential to main-
28 taining life in certain cases. At present there is
29 no fixed pattern for the provision of such drugs.

30 220. Various agencies assist, e.g., a public

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211. "Prescription" drugs are obtained from drug stores based on an order from a physician - a charge is usually made by the druggist over and above the cost of the drug.

212. In all general hospitals, all necessary drugs ordered by the physician are covered by the Hospital Insurance Plan.

213. Biologics for prevention of communicable diseases are available from the Department of Public Health on a free basis - provided the physician provides the service on a free or reduced charge basis. Such drugs are also provided free for public clinics - examples are polio vaccine, measles vaccine.

214. On a mass test basis, the Government also provides insulin, anti-diabetic drugs and test material to those suffering from diabetes mellitus.

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216. Free drugs are also provided by the Government for treatment of tuberculosis, both in and out of hospital.

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218. "Special Drugs" - some of the newer drugs are very expensive - some of these are essential to maintaining life in certain cases. At present there is no fixed pattern for the provision of such drugs.

219. Various agencies assist, e.g., a public



1 dispensary at the Dalhousie Public Health Centre,
2 voluntary agencies, municipalities; however, in
3 general, the citizen himself must find the means to
4 obtain the necessary drug.

5 221. Some physicians continue to dispense
6 drugs; again, however, this is on a fee basis.

7 222. The drug situation is a most confused one
8 - particularly in the self medication field. Large
9 sums are spent by the citizen in the purchase of pro-
10 prietary and other drugs without there being any
11 scientific reason for their use. Tons of "aspirin",
12 sleeping pills, tranquilizers, etc., are used in
13 Canada without any control or advice of medical
14 practitioners. It would appear that we are becoming
15 a nation which cannot get along without drug stimu-
16 lation or sedation.

17 223. Another field where drugs can affect health is
18 that of food preservatives. Although this field
19 is carefully watched by the Department of National
20 Health and Welfare, the situation is becoming in-
21 creasingly complex and difficult. Again, drugs used
22 in cattle and poultry may reflect in human food, e.g.,
23 penicillin in milk and sex hormones in beef.

24 224. Many complaints are heard regarding the high
25 cost of drugs - others complain that physicians pre-
26 scribe too many high cost drugs. In some areas the
27 physicians complain that patients demand drugs which
28 are not required - the druggists complain they have
29 to carry oversize inventories because of the rapid
30 change-over of drugs and the demand for "newer" drugs.



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change-over of drugs and the demand for "newer" drugs.



1 All in all, the picture is most confusing - one
2 thing is clear - if included in a health program the
3 cost of drugs is a major item and will probably in-
4 crease.

5
6 DENTAL CARE

7 225. The greater part of the dental care to
8 citizens of Nova Scotia is provided through private
9 practitioners on a fee basis. Little or no service
10 is paid for through insurance schemes except for one
11 small group plan in the Liverpool area.

12 226. The Federal Department of Veterans Affairs
13 provide dental service to certain groups of veterans
14 both through the Dental Clinic at Camp Hill Hospital
15 and private practitioners throughout the Province -

16 (a) to veterans for conditions associated with
17 their pensionable disability

18 (b) Recipients of War Veterans Allowance

19 (c) Patients admitted to Camp Hill Hospital

20 There are approximately 60,000 veterans in the Pro-
21 vince.

22 227. The Department of Public Health have
23 provisions and funds to provide a dental service to
24 certain rural residents under twelve years of age
25 but have been unable to obtain dentists to staff this
26 service during the past year.

27 228. In institutions under the direction of the
28 Department of Public Health, a part time dental ser-
29 vice is provided when dentists are available, e.g.,
30 at the Nova Scotia Hospital and the Nova Scotia
Sanatorium.

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also is provided when dentists are available, at the Nova Scotia Hospital and the Nova Scotia



1 229. Dental Service to a small number of
2 patients is also provided in the City of Halifax through
3 the clinic service at the Dalhousie Dental School.

4 230. In the Halifax City schools there are em-
5 ployed on a salary basis three half-time dentists.

6 231. In a few towns, attempts have been made to
7 operate part time dental clinics - but due to the short-
8 age of dentists such projects are not too successful.

9 232. In the Town of Shelburne, a trust has been
10 set up by the McKay Estate providing for the half time
11 service of a dentist on a free basis to look after the
12 dental needs of children.

13 233. Aside from financial considerations, the main
14 difficulty in obtaining dental service would appear
15 to be an acute shortage of dentists. As with
16 physicians there is a marked tendency for dentists
17 to congregate in urban areas with consequent lack
18 of dentists in rural areas. But even in urban areas
19 such as Halifax there is a definite shortage of
20 dentists - further, dental specialists in such fields
21 as orthodontia are also in short supply.

22 234. It has been stated that the current supply
23 of practising dentists in the province is only suf-
24 ficient to meet the dental needs of 25 per cent of the
25 population.

26 235. From figures available from the Canadian
27 Dental Association and using the number of dentists on
28 the Register rather than the number in actual practice,
29 it would appear that in Canada in 1961 there are 3037
30 population per dentist. In Nova Scotia, there are 3689

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the clinic service at the Dalhousie Dental School

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such as Halifax there is a definite shortage of

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as orthodontia are also in short supply.

234. It has been stated that the current supply

of practicing dentists in the province is only suf-

ficient to meet the dental needs of 85 per cent of the

235. From figures available from the Canadian

Dental Association and using the number of dentists on

the Register rather than the number in actual practice,

it would appear that in Canada in 1961 there are 2077



1 per dentist.

2 236. By using the number of dentists in actual
3 practice, (158), instead of the number on the Register,
4 (234), a ratio of 4720 population per dentist is ob-
5 tained.

6 237. It is stated by competent authorities that
7 one dentist can give a comprehensive service to 1,000
8 persons per year.

9 238. To further emphasize the increasing shortage
10 of dentists, information would indicate that since
11 1951 the dental population increased only by 2.1 per
12 cent while the general population increased by 16.2
13 per cent.

14 239. To illustrate the discrepancy in service
15 between urban and rural areas, it is noted that of all
16 the dentists in Nova Scotia, 39 per cent are in the
17 Halifax - Dartmouth Metropolitan area; 17 per cent in
18 the Cape Breton Metropolitan area - thus, these two
19 largely urban areas have 56 per cent of all the dental
20 practitioners in the province while having only about
21 35 per cent of the population.

22 240. There is an ever increasing demand for
23 dental services in all parts of the province.

24 241. What has been done to attempt to deal with the
25 situation?

26 (I) A Division of Dental Services was
27 created in the Provincial Department - the main objec-
28 tive of this Division is prevention of dental caries
29 through health education. Emphasis was placed
30 on proper nutrition for mother and child, on proper

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1 dental hygiene and early correction of dental defects
2 - later, promotion of fluoridation programs was em-
3 phasized - at present, about 22 per cent of the
4 population are using fluoridated communal water.

5 242. In an attempt to at least deal with urgent
6 dental problems among children in the rural areas
7 where private dentists were not available, the Divi-
8 sion put into operation three mobile dental units -
9 however, as stated previously, these were not
10 operated this year due to lack of dental staff.

11 (2) Dental Hygienists were employed by the
12 Department of Public Health.

13 243. A dental hygienist is basically an educator
14 in dental health and deals largely with children -
15 in addition, they are trained in the prophylactic care
16 of teeth and in the application of fluoride on an
17 individual basis as a preventive for dental caries.

18 The above personnel were trained under
19 National Health Grants and operate in rural areas with
20 the Health Units - it is felt that their work is of
21 considerable value in the dental program of the
22 province.

23 (3) The Dental School was Enlarged

24 244. In 1958 a new larger, modern Dental School
25 was opened at Dalhousie University with facilities
26 to graduate 25 dentists per year after a four-year
27 course. It must be realized that the Dalhousie Dental
28 School is intended to provide graduates for the four
29 Atlantic Provinces. Of the 59 students presently in the
30 Dental School, only 19 are from Nova Scotia. So



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1 that the School is operating at slightly over 50 per
2 cent of capacity with Nova Scotia students far below the
3 proportion based on population of the four Atlantic
4 provinces. Something must be changed so as to
5 encourage more young men and women to enter the pro-
6 fession of dentistry which has vacant training facili-
7 ties and many opportunities for practice.

8 245. A further development in the Dental School
9 in 1961 has been the opening of a school for Dental
10 Hygienists - previously such training was only available
11 in the Central Provinces and the United States.
12 Training facilities exist to graduate 12 each year.
13 In this, the first year, eight students have started
14 on the 2-year course - four of these are from Nova
15 Scotia.

16 246. It has been stated that even if the Dental
17 School was filled to capacity and all the graduates
18 stayed in Nova Scotia and the other Atlantic Provinces,
19 that it would be many years before sufficient dentists
20 would be present to meet the needs. Economics result
21 in a substantial number leaving Nova Scotia for other
22 places where a larger income can be earned.

23 247. The Army Training Scheme with its substantial
24 bursary assistance has been successful in improving
25 the dental situation in the Armed Forces - at the same
26 time it has drained away graduates who, under other
27 circumstances, might have stayed in Nova Scotia. Pos-
28 sibly a similar scheme operated by the Province might
29 assist in retaining dentists in Nova Scotia.

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248. It has been stated that the high cost of

obtaining training, the high cost of equipment, etc., for practice and the uncertainty of income in many areas under the present fee for service method of remuneration keeps students out of the dental field. A scheme of assisting students plus a "dental insurance" scheme should be given serious consideration.

TO SUMMARIZE THE DENTAL SITUATION -

- (a) The training facilities at the Dental School are not being utilized to capacity.
- (b) Not enough Nova Scotia students are entering the Dental School.
- (c) Since 1951 the "dental population" in Nova Scotia has only increased by 2.1 per cent, while the general population has increased by 16.2 per cent.
- (d) Subsidization of dental students by the Army is a factor in reducing the number of graduates for Nova Scotia - this is not a criticism of the scheme which is an excellent one, and a similar scheme might be considered.
- (e) There are far too few dentists available to Nova Scotia for the need.
- (f) Dental costs, while not excessively high, are still beyond the reach of many of our citizens.
- (g) Not enough communities are taking advantage of fluoridation to lower the incidence of dental caries among children.

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(a) The training facilities at the Dental School

are not being utilized to capacity.

(b) Not enough Nova Scotia students are entering

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(c) Since 1951 the "dental population" in Nova

Scotia has only increased by 5.1 per cent.

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16.2 per cent.

(d) Graduation of dental students by the

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(f) Dental costs, while not excessively high,

are still beyond the reach of many of our

citizens.

(g) Not enough communities are taking advantage

of fluoridation to lower the incidence of

dental caries among children.



(h) More emphasis should be placed on the improper use of "sweets" by children and leading to dental caries - nutrition information is not being put to use by the people.

(i) More specialists are needed to deal with corrections, misplaced teeth, malocclusion, etc.

(j) Some action must be taken to ensure improved dental care for rural areas of the province.

(k) There are a large number of "dental indigents" who cannot afford the cost of dental treatment with consequent ill effects on their health and morale.

(l) Dental Insurance plans, similar to Medical Care Insurance Plans, may be necessary.

SCHOOL HEALTH SERVICES

TEACHERS

249. All teachers, before gaining entrance to a teacher training institution must present a certificate from a physician testifying as to the health of the applicant - the onus of obtaining and paying for the examination is on the candidate.

250. Teachers coming from outside the province must submit a certificate from a physician indicating their health status.

251. Teachers in service must have a yearly chest x-ray or tuberculin test indicating their freedom from pulmonary tuberculosis.

252. To promote the teaching of health and physical education courses are given at the teacher training



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from tuberculosis.

To promote the teaching of health and physical
education courses are given at the teacher training

institutions, at the Nova Scotia Summer School for teachers and at institutes, etc.

253. Further, assistance is given the teachers in the field of health teaching by Public Health Nurses, Nutritionists, etc., from the Department of Public Health.

SCHOOL CHILDREN

254. A modern school entering system should require that children entering school for the first time present a certificate from a physician indicating (a) that the child is physically and mentally normal or if not indicating the defect present with a recommendation as to physical activity (b), that the child has been immunized against smallpox (or a conscientious objector's certificate presented) (c), any other immunization procedures carried out.

255. There is considerable doubt as to whether the educational or public health authorities should be responsible for the finding of physical and mental defects in school children. It is strongly suggested that this is the responsibility of the parent and the family physician and should largely be dealt with before the child enters school.

256. In some areas, school authorities require a medical certificate before the child is admitted for the first time to a school - however, at present, most school authorities do not make such a requirement.

257. Again, with regard to compulsory vaccination against smallpox, many schools require new pupils to present a certificate of successful vaccination or a



teachers and statisticians, etc.

253. Further, assistance is given the teachers in the field of health teaching by Public Health Nurses, Nutritionists, etc., from the Department of Public

254. A modern school entering system should re-

quire that children entering school for the first time present a certificate from a physician indicating (a) that the child is physically and mentally normal or if not indicating the defect present with a recommendation as to physical activity (b), that the child has been immunized against measles (or a combination of objects a certificate presented) (c), any other immunization procedures carried out.

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257. Again, with regard to compulsory vaccination against smallpox, many schools require new pupils to present a certificate of successful vaccination or a

1 conscientious objector's certificate - many others do
2 not and some pupils go through their entire school life
3 without this protection.

4 EXAMINATION OF SCHOOL CHILDREN

5 258. There are several systems in vogue in the
6 Province.

7 (a) Some school boards require a medical
8 certificate from the family physician before
9 a child is admitted to school for the first
10 time - by far the larger number of school
11 boards to not require this.

12 (b) Some areas have a medical examination of
13 school children carried out by physicians
14 employed by the Board of Health, e.g., the
15 City of Halifax.

16 (c) By far the largest number of school children
17 are given an examination by a Public Health
18 Nurse consisting of vision and hearing
19 testing, examinations of the teeth, skin
20 and scalp and an examination for obvious
21 physical and mental defects. The nurse
22 makes a report to the school authorities and
23 the parents. The parents are expected to take
24 the child to the family physician for diagnosis
25 and correction of possible defects.

26 259. Various other Department of Public Health
27 personnel assist with the school health program - the
28 Director of the Health Unit gives talks on health
29 subjects, an audiometer technician checks hearing
30 defects, nutritionists discuss the school lunch and

few years ago, many of the
and some people, through their school life

THE SCHOOL CHILD

There are several things in view in the

These school boards require a teacher

a child is admitted to school on the 1st

time - by the parent, teacher or school

boards in the following order:

(b) Some cases have a medical examination of

school and then carried out of physicians

employed on the basis of health, etc.

(c) By the largest number of school children

are given an examination by a public health

house consisting of vision and hearing

testing, examination of the chest, skin

and scalp and an examination of the nose

physical and mental status. The nurse

makes a report to the school authorities and

the parent. The parent is expected to pay

the cost of the health examination for his child.

and a record of the child's health.

Various other departments of public health

boards, an additional health board

1 nutrition generally and the dental hygienist talks
2 on tooth health, gives prophylactic treatment and
3 gives local fluoride treatment to young children.

4 260. While the teacher is responsible for the
5 health program in the school, every assistance is
6 given by the personnel noted above. Just how well the
7 health education program is taught will depend on the
8 interest and ability of the teacher.

9
10 SCHOOL BUILDINGS AND GROUNDS

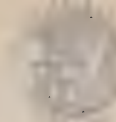
11 261. New buildings are built under a scheme
12 of shared financial responsibility between the
13 Provincial and Municipal Governments. The Department
14 of Public Health advises on the plans with regard to
15 the side with particular reference to water supply,
16 sewage collection and disposal and playground.

17 262. Sanitary Inspectors of the Department of
18 Public Health provide a consultant service on any
19 sanitary problem in the schools.

20 263. From a housing point of view, the health of
21 school children should be better in the future -
22 the school building program is very active and the
23 new buildings are modern in all respects, ventilation,
24 lighting and toilets, etc.

25 COMMUNITY PLANNING

26 265. No planning proposals are made by the
27 Community Planning Division of the Department of
28 Municipal Affairs without careful consideration of
29 the water and sewer problem. It could be said that
30 there is no real problem in town planning except the



given by the personnel noted above. Just how well the health education program is taught will depend on the interest and ability of the teacher.

SCHOOL BUILDINGS AND GROUNDS

261. New buildings are built under a scheme of shared financial responsibility between the
- of Public Health advises on the plans with regard to the site with particular reference to water supply, sewage collection and disposal and playground.
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COMMUNITY PLANNING

264. No planning proceeds are made by the Community Planning Division of the Department of Municipal Affairs and are carried out in cooperation of the water and sewer problem. It could be said that



1 sewer problem. In every town highly desirable
2 residential sites are undeveloped due to the excessive
3 cost of sanitary drainage.
4 266. The septic tank will work in many areas
5 provided piped water from a safe source is available.
6 However, septic tanks and disposal fields must be
7 properly installed and maintained. If one person
8 in twenty refuses to do this the effect is nearly as
9 bad as if all were careless. The planner can recog-
10 nize the unpleasantness of improperly installed pri-
11 vate sewage systems but unfortunately the direct
12 health hazard is uncertain or unproved so that people
13 are not concerned enough to force action from the
14 local health authorities. Every means available
15 are used to prevent housing developments where sanitary
16 sewers are not available or cannot readily be made
17 available. A great measure of control in this
18 matter rests with Central Mortgage and Housing Cor-
19 poration who can refuse loans where the above conditions
20 do not exist. A more positive statement on private
21 sewage disposal would be of assistance in planning.
22 There is also need of some simple measure of allowable
23 pollution in tidal rivers relating the size of the
24 body of water in relation to the volume of sewage.
25 267. The opinion has been expressed that the best
26 way to control pollution is through a Water Resources
27 Commission similar to that in Ontario and other pro-
28 vinces, and through greater coordination between public
29 health, fisheries, public works, and town planning
30 authorities.

... In every town highly desirable

residential sites are undeveloped due to the excessive cost of sanitary drainage.

The septic tank will work in many cases

provided rigid water from a safe source is available.

However, septic tanks and disposal fields must be

properly installed and maintained. It is a common

in twenty years to do this the effect is nearly as

bad as if all were careless. The danger can recog-

nize the unpleasantness of improperly installed pri-

vate sewage systems but unfortunately the direct

health hazard is less than in unimproved so that people

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way to control pollution is through a Water Resources

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1 268. In the overall planning picture or more
2 particularly in regional planning there is concern for
3 the rural slum, more so than local housing in the
4 towns. It would be hard to prove that a tar paper
5 shack is an unhealthy place to live provided it is clean
6 and the occupants are adequately fed. One deficiency,
7 however, is usually the sign of the other and we be-
8 lieve placing safe, sanitary housing within the reach
9 of these people would improve the general health of
10 the area. The design problem has apparently been
11 solved and can bring the cost of an adequate, safe,
12 sanitary, warm, three-bedroom house down to \$3500.00.
13 However, there still remains the problem of a plan of
14 local government action. Federal help in finance might
15 be welcome but planning and administration should be
16 a local matter entirely.

17 Source - Provincial Department of Municipal
18 Affairs.

19 HOUSING

20 269. Good housing is most effective in the pre-
21 ventation of disease, in all probability not so much be-
22 cause it provides means of reducing contagion or
23 destroying germs as because of the part which it may
24 play in the building up of resistance. Human beings
25 vary quite considerably in their relative constitution-
26 al immunity to specific diseases, but a given indivi-
27 dual's susceptibility to many diseases, as for example
28 tuberculosis, may be considerably affected by his mode
29 of living. Resistance may be reduced by overwork,
30

in regional planning there is concern for

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Source - Provincial Department of Municipal

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al immunity to specific diseases, but a given individ-

ual's susceptibility to many diseases, as for example

tuberculosis, may be considerably affected by his mode

of living. Resistance may be reduced by overwork,



1 undernourishment, and apparently also by inadequate or
2 inappropriate exercise. It may be increased by
3 living in fresh air. It is probable also that sun-
4 shine plays a quite important part in increasing
5 human resistance. In so far as improved housing
6 tends therefore to increase the amount of fresh air
7 and of sunshine in the homes of all classes, it pre-
8 sumably tends to increase resistance to disease.
9 This, if true, offers the most cogent argument of
10 all for the maintenance of strict standards through
11 housing legislation.

12 270. It should be understood that housing conditions
13 are never the sole cause of disease. There may be a
14 constitutional predisposition, hereditary or acquired.
15 In the case of infectious diseases, the germ must be
16 present and ingested in infective quantities. Each
17 illness is a resultant of the interplay of many factors
18 operating within the individual and within his physical
19 and social environment. Medical specialists dis-
20 agree as to the mode of infection or acquirement of
21 many diseases. Nevertheless, the burden of proof
22 lies with the person who criticizes the general view
23 of the pathologists and quarrels with the experience
24 of health departments and investigators. Bad housing
25 conditions of various sorts are factors in the reduction
26 of health and in the spread of a variety of diseases.
27 Improvement of housing conditions will serve to reduce
28 the volume of preventable diseases and accidents.

29 REHABILITATION OF THE DISABLED IN NOVA SCOTIA
30

271. A number of government departments and



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of health and in the spread of a variety of diseases.
Improvement of housing conditions will serve to reduce
the volume of preventable diseases and suffering.



1 voluntary organizations are involved in the rehabili-
2 tation of physically and mentally handicapped persons
3 in Nova Scotia. A function of the office of the
4 Co-ordinator of Rehabilitation in the Department of
5 Public Health is to see that these various services
6 are so co-ordinated and integrated as effectively as
7 possible.

8 272. Services may be divided into two classifi-
9 cations - Treatment and Restoration and Vocational and
10 Social Rehabilitation.

11 TREATMENT AND RESTORATION

12 273. Main centres providing treatment and restora-
13 tion services are the Nova Scotia Rehabilitation Centre
14 and the Victoria General Hospital. It may be said that
15 the latter provides acute treatment service while the
16 former provides continuing restorative and recondition-
17 ing therapy in the post acute phase coupled with psycho-
18 logical, social and vocational rehabilitation services.

19 274. Some regional hospitals are including
20 modified physical rehabilitation departments in their
21 developments under the Hospital Insurance Plan. Four
22 general hospitals have such services now.

23 275. Treatment and restoration services for the
24 tuberculous are provided in two provincially operated
25 hospitals. (See report on Tuberculosis Control).

26 276. Treatment and restoration services for the
27 mentally ill are provided in the provincially operated
28 Nova Scotia Hospital and in a number of provincially
29 supported but community operated mental health clinics.
30 (See report on Mental Health Services).



Public Health is to see that these various services
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278. Services may be divided into two classes:-

Options - Treatment and Restoration and Vocational and
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TREATMENT AND RESTORATION

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280. Some regional hospitals are including

modified physical rehabilitation departments in their
development under the Hospital Insurance Plan. Some
general hospitals have such services now.

281. Treatment and restoration services in the

theatricals are provided in two provisionally organized
hospitals. (See report on Theatricals Section)

282. Treatment and restoration services for the

mentally ill are provided in the provisionally organized
Nova Scotia Hospital and in a number of provisionally



1 277. The Canadian Arthritis and Rheumatism
2 Society operates mobile physiotherapy units in five
3 communities. Treatment for these disabilities is
4 carried to the bedside.

5 Vocational and Social Rehabilitation

6 278. It is in the field of vocational and social
7 rehabilitation that voluntary organizations make their
8 most significant contribution.

9 279. The Nova Scotia Society for Crippled Children
10 maintains (with provincial assistance) a crippled
11 children's register, and conducts mobile diagnostic
12 clinics in thirteen centres of the province. The
13 Society also has a field worker whose function is to
14 follow up on clinic recommendations and to refer cases
15 to the provincial rehabilitation services on becoming
16 of age.

17 280. The Canadian Paraplegic Association, Maritime
18 Division, provides field counselling to all paraplegics
19 in the province, furnishes wheel chairs, home aids and
20 educational aids. The Association has one field officer
21 who works in close liaison with the treatment centres
22 and the provincial rehabilitation services.

23 281. The Nova Scotia Division of the Canadian
24 Foundation for Poliomyelitis has two travelling
25 physiotherapists who visit and counsel post-polio cases
26 in their homes. In addition, the "March of Dimes"
27 together with the Junior League of Halifax operates the
28 only sheltered workshop in Nova Scotia. It refers all
29 cases for vocational rehabilitation to the provincial
30 rehabilitation services.

Vocational and Social Rehabilitation

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299. The Nova Scotia Society for Crippled Children

maintains (with provincial assistance) a crippled children's register, and conducts similar diagnostic clinics in thirteen centres of the province. The Society also has a field worker whose function is to follow up on clinic recommendations and to refer cases to the provincial rehabilitation services or to the local services.

Division, provides field consultation to all hospitals in the province, furnishes wheel chairs, home aids and educational aids. The Association has one field officer who works in close liaison with the treatment centres and the provincial rehabilitation services.

301. The Nova Scotia Division of the Canadian

Foundation for Polio Research has two travelling physiotherapists who visit and conduct post-polio cases in their homes. In addition, the "March of Dimes" together with the Junior League of Halifax operates an only sheltered workshop in Nova Scotia. It refers all cases for vocational rehabilitation to the provincial



1 282. The Nova Scotia Tuberculosis Association
2 assists in vocational and social rehabilitation of the
3 ex-tuberculous by providing financial loans.

4 283. The Canadian Mental Health Association, Nova
5 Scotia Division, promotes the establishment of com-
6 munity mental health clinics, liases with the Nova Scotia
7 Hospital and refers appropriate cases to the pro-
8 vincial rehabilitation service for vocational rehabi-
9 litation.

10 284. The Nova Scotia Association for Retarded
11 Children promotes the establishment of community
12 training and education facilities. There are special
13 classes for the trainable but not educable in several
14 towns.

15 285. The Canadian Red Cross Society assists in the
16 purchase of artificial limbs and appliances and the
17 provision of wheelchairs.

18 286. The Nova Scotia Rehabilitation Council, a
19 voluntary organization, in addition to operating the
20 Nova Scotia Rehabilitation Centre, operates (with pro-
21 vincial assistance) the Nova Scotia Brace and Appliance
22 Centre - a complete brace and orthopedic boot service.
23 It is expected that a limb service will be developed
24 in the near future.

25 287. The services of the Canadian National Insti-
26 tute for the Blind are too well known to require more than
27 mention here.

28 288. Government services in social and vocational
29 rehabilitation include special training services of
30 the Division of Vocational Education and the regular



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tute for the Blind are too well known to require more than

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288. Government services in social and vocational

rehabilitation include special training services of

the Division of Vocational Education and the regular



1 apprentice training program of the Department of Labour
2 in addition to the services described below of the
3 Rehabilitation Division of the Department of Public
4 Health.

5 289. The Rehabilitation Division of the Depart-
6 ment of Public Health provides a variety of direct
7 and indirect services in the process of rehabilita-
8 tion of disabled persons.

9 Direct Services

10 290. 1. Medical Assessment

11 An internist and a physiatrist are employed
12 on a per half day basis as members of the Rehabilita-
13 tion Assessment Team to assess residual physical and
14 mental ability and to relate these capacities to
15 vocational objectives. They have authority to consult
16 specialists concerning specific medical conditions
17 when necessary and may recommend treatment.

18 291. 2. Provision of Prosthetic Appliances

19 On recommendation of the Rehabilitation
20 Assessment Team and the Provincial Co-ordinator,
21 assistance may be given in the purchase of prosthetic
22 appliances for persons for whom no other source of
23 financial assistance is available.

24 3. Maintenance During Out-patient Treatment

25 292. The Rehabilitation Assessment Team and the
26 Provincial Co-ordinator may approve maintenance and
27 local transportation for persons receiving treatment at
28 an approved treatment centre.

29 4. Counselling in the Field

30 293. The Division maintains rehabilitation

Rehabilitation Division of the Department of Public Health

The Rehabilitation Division of the Department of Public Health provides a variety of direct and indirect services in the process of rehabilitation of disabled persons.

290. 1. Medical Assessment

An interview and a physical examination are employed on a regular basis as members of the Rehabilitation Assessment Team to assess residual physical and mental ability and to relate these assessments to vocational objectives. They have authority to consult specialists concerning specific medical conditions when necessary and may recommend treatment.

290. 2. Recommendation of the Rehabilitation Assessment Team and the Provincial Coordinator

Recommendations may be given in the purchase of prosthetic appliances for persons for whom a special course of treatment is available.

290. 3. Maintenance During Out-patient Treatment

The Rehabilitation Assessment Team and the Provincial Coordinator may arrange assistance and local transportation for persons receiving treatment at

4. Counseling in the Field



1 in Yarmouth, Halifax and Sydney. These counsellors
2 provide a continuing counselling service to disabled
3 persons in their homes, on-the-job or in training.
4 It is expected that this service will be extended
5 so as to provide more adequate and more frequent
6 coverage of the field territory.

7 5. Vocational Assessment and Preparation
8 for Training.

9 294. Through its field counselling service,
10 the Division assesses vocational potential and recom-
11 mends training or employment consistent with the
12 physical and mental capacities of rehabilitants. When
13 completely worked up, applications for training are
14 referred to the Division of Vocational Education which
15 operates the training facilities.

16 6. Rehabilitation of the Ruberculous
17 295. Rehabilitation services for the ruberculous
18 while under treatment are provided through Tuberculosis
19 Control Services. On discharge from hospital, the ex-
20 tuberculous receive the same services available to
21 persons having other disabilities.

22 INDIRECT SERVICES

23 296. The office of the Provincial Co-ordinator of
24 Rehabilitation liaises with the Nova Scotia Rehabili-
25 tation Centre, the Victoria General Hospital and
26 other hospitals and with doctors and clinics concerning
27 referrals and possible referrals.

28 297. Integration of the services of the Division
29 with services provided by voluntary organizations
30 concerned with specific groups of disabled people is



294. Through its field counselling service, the Division assesses vocational potential and recommends training or employment opportunities. When physical and mental capacities of individuals are completely worked out, applications for training are referred to the Division of Vocational Education which operates the training facilities.

6. Rehabilitation of the Handicapped
295. Rehabilitation services for the handicapped while under treatment are provided through the following Control Services. On discharge from hospital, the handicapped receive the same services available to persons having other disabilities.

296. The office of the Provincial Coordinator of Rehabilitation works with the Nova Scotia Rehabilitation Centre, the Victoria General Hospital and other hospitals and with doctors and clinics concerning referrals and possible rehabilitation.

297. Integration of the services of the Division with services provided by voluntary organizations concerned with special groups of disabled people.



1 an important function.

2 298. Liaison is carried out with the Department
3 of Public Welfare, the Department of Education and
4 the Department of Labour as a means of providing services
5 where possible to public assistance cases and of
6 effecting training and placement in those cases where
7 this can be achieved.

8 UNMET NEEDS

9 299. Main difficulties met in providing rehabili-
10 tation services are disability, age and education in
11 varying combinations. Extensions of services which
12 could do much to increase the likelihood of successful
13 rehabilitation are:

14 1. Early Case Finding and Referral

15 300. This is largely a matter of communications.
16 Many medical practitioners and hospitals are not aware
17 of the services available. The public health nursing
18 service, the informed agency closest to the home and
19 community, and the school authorities can improve
20 their referral services. More information must reach
21 these referral sources regularly.

22 2. Restoration Services

23 301. An extension of restoration services for
24 the physically and mentally handicapped is needed.
25 Regional hospitals are not paying enough attention to
26 the recruitment and training of rehabilitation per-
27 sonnel such as physical and occupational therapists.
28 If sufficient medical specialists are not available
29 to supervise treatment by therapists in these hospitals,
30 arrangements should be made to send qualified physicians

on "milk routes" from Halifax. In some cases transportation to the central treatment services, in addition to maintenance while on out-patient treatment, will fill a real need.

302. More clinics for treatment of the mentally handicapped are needed so as to provide adequate assessment of rehabilitation possibilities and supportive therapy.

3. Education

303. Inability to deal effectively with adolescents and adults with congenital disabilities or disabilities acquired at an early age is related in part to lack of education. This is particularly noted in the handicapped from rural areas. A practical solution would be the establishment of special education facilities for physically handicapped and trainable mentally retarded children at regional high schools, which are transportation fed.

PUBLIC HEALTH SERVICES

304. Such services are provided throughout the Province by voluntary associations, municipal and Provincial Governments. Financial assistance through Health Grants is also provided by the Federal Government. The physicians of the Province give considerable time and effort in assisting both voluntary and official agencies.

Voluntary Associations

305. A large number of associations provide a Public Health Service especially in the health education field. Other organizations such as the Nova Scotia Tuberculosis

302. More clinics for treatment of the mentally

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3. Education

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Other organizations such as the Nova Scotia Tuberculosis



1 Association carry out service programmes using their
2 own personnel, e.g. the Heaf Test (tuberculin) pro-
3 gramme. Whole counties have been surveyed and the
4 positive reactions offered a chest x-ray examination
5 by the Department of Public Health - this is an
6 excellent example of cooperation between official
7 and voluntary agencies in the public health field.

8 Municipal

9 306. Although the Public Health Act gives to
10 Municipal Boards of Health very extensive powers, such
11 powers have been largely in abeyance during recent
12 years except in a few areas such as the City of
13 Halifax, which has developed an excellent programme
14 in a Municipal Health Unit staffed with trained
15 physicians, public health nurses, sanitary inspectors,
16 etc.

17 307. Most municipalities appoint a part time
18 medical officer of health - he is usually paid only a
19 nominal sum (\$200. - \$500.) per year. Meetings of
20 Boards of Health are not always held regularly and the
21 tendency has been to pass along responsibility for
22 public health work to the Provincial Health Units.
23 (These will be discussed later.)

24 308. With the exception of Halifax City there
25 are no trained or qualified public health personnel
26 employed by municipal authorities.

27 309. In some towns the Municipal Health Officer
28 does medical inspections of school children - in
29 others public immunization clinics are operated -
30 emergency situations are dealt with by some. Some

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powers have been largely in abeyance during recent

and, although the Public Health Act gives the

excellent example of cooperation between officials

by the Department of Public Health - this is an



1 Boards of Health employ personnel to inspect restaur-
2 ants and milk supplies - but in actual fact most of
3 this work is carried out by the Provincial Health Unit
4 personnel who report in turn to the municipal authori-
5 ties. - it is expected that any legal action necessary
6 will be taken by the municipal authority.

7 310. There has developed more and more dependency
8 on the Health Unit, so much so that suggestions have been
9 made to abolish the present Municipal Board of Health
10 System and replace it by Health Unit authority with an
11 Advisory Board from Municipalities.

12 311. The Province has been divided into eight
13 Health Units - these, with the City of Halifax Health
14 Unit give complete public health coverage for all parts
15 of the province.

16 312. A decentralized type of administration is in
17 effect with the Central Office in Halifax and Health
18 Unit offices in Sydney (2), Pictou, Windsor, Truro,
19 Dartmouth, Bridgewater and Yarmouth. (See Map)

20 313. The Health Units are comprised of from 1 to
21 3 counties with populations varying from 48,000 in
22 Lunenburg-Queens to 120,000 in the Atlantic Unit
23 (Halifax Co.).

24 314. Staff consists of a qualified public health
25 trained physician (Director), a staff of qualified public
26 health nurses, certified nursing assistants, qualified
27 sanitary inspectors and clerks.

28 315. In addition either part of full time services
29 of a qualified nutritionist, a dental hygienist, and
30 audiometer technician are provided to the Health Unit.

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310. There has developed more and more dissatisfaction with the present Municipal Board of Health System and replace it by Health Unit authority with an

311. The province has been divided into eight Health Units - three, with the City of Halifax Health Unit give complete public health coverage for all parts of the province.

312. A decentralized type of administration is in effect with the Central Office in Halifax and Health Unit offices in Sydney (S), St. John's, Windsor, Toronto, Dartmouth, Bridgewater and Yarmouth (see Map).

313. The Health Units are comprised of from 7 to 3 counties with populations varying from 25,000 in Lunenburg-Queens to 125,000 in the Atlantic Unit.

314. Staff consists of a qualified public health trained physician (physician), a staff of qualified public health nurses, certified nursing assistants, qualified sanitary inspectors and clerks.

315. In addition other part of full time services of a qualified nutritionist, a dental hygienist, and a pharmacist are provided in the Health Unit.



1 Some Units also have the services of a vocational
2 counsellor to assist in the rehabilitation programme.
3 316. All necessary consultants are provided from
4 the Central Office - sanitary engineer, rehabilitation
5 co-ordinator, nurse consultant in obstetrics, account-
6 ing, mental health, epidemiology, radiation hazards and
7 venereal disease.

8 317. Thus it will be seen that each Health Unit
9 is a small Department of Public Health - general poli-
10 cies are uniform throughout but differences in operation
11 of a programme result from varying conditions, e.g.
12 a rural area and an industrial area.

13 318. To ensure a reasonable amount of uniformity
14 at least two meetings a year of the staff are held at
15 which programme matters are discussed, changes suggested,
16 newer developments outlined - actually a form of in-
17 service training.

18 319. In addition there is held in the Halifax
19 Office, bi-weekly meetings of all the Administrators and
20 Directors of Divisions - policy is discussed and ex-
21 plained and problems are given attention. At inter-
22 vals each Administrator or Director reviews his area
23 of responsibility - again a form of inservice training
24 and assessment of programmes.

25 Programme

26 320. The basic objectives of all phases of the
27 programme is prevention of disease and the promotion of
28 good health. For various reasons treatment of certain
29 diseases, such as tuberculosis has become a part of the
30 programme of public health - possibly in this case on the



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1 premise that isolation and treatment of a case will,
2 in addition to improving the patient, prevent further
3 spread of the disease. The programme will be dis-
4 cussed under various hearings:

5 321. (a) Sanitation - deals with milk, water,
6 food and environment - both from the inspection and
7 health education point of view.

8 322. All milk producers in the province are li-
9 censed by the Board of Public Utilities after an inspec-
10 tion by the Department of Public Health - this applies
11 also to Distributors, milk plants and pasteurization
12 plants - a major amount of time is spent in teaching
13 producers how to produce clean milk. Simply quality
14 tests are carried out both in the pasteurization plants
15 and by the sanitary inspectors. Other laboratory work
16 is done in the Central and Regional laboratories.

17 323. At present about 97 per cent of the milk used
18 in cities, towns and large villages is pasteurized.
19 There is no compulsory pasteurization law throughout the
20 province although several towns have such a local bylaw.

21 324. Bovine tuberculosis has practically disap-
22 peared largely as a result of the tuberculin test
23 and slaughter programme of the Departments of
24 Agriculture.

25 325. Brucellosis (Bangs Disease) appears to be
26 coming under control - there are very few human cases
27 reported - most of these arise in the rural population
28 from using unpasteurized milk.

29 326. Mastitis in cows has been assuming larger
30 proportions - fortunately pasteurization lessens the



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reported - most of these arise in the rural population
from using unpasteurized milk.

326. Mastitis in cows has been assuming larger
proportions - fortunately pasteurization lessens the



1 menace to humans, however there is a large economic
2 loss to the farmer. Recently it has developed that
3 the use of penicillin and other antibiotics in treating
4 mastitis may be getting into milk supplies with sub-
5 sequent danger to those sensitive to penicillin and
6 other antibiotics.

7 327. The manufacture of butter, ice cream and
8 other milk products also comes under the inspection
9 programme in association with the Department of Agri-
10 culture.

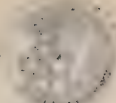
11 328. All public water supplies are inspected and
12 tested by Department of Health personnel - chlorina-
13 tion equipment is tested as well as fluoridation equip-
14 ment and methods. It is worthy of note that 22 per cent
15 of the population of Nova Scotia are using fluorida-
16 ted water - check surveys indicate the value of this
17 procedure in preventing dental caries in young chil-
18 dren.

19 329. On request sanitary surveys and testing
20 of private water supplies are carried out.

21 330. All schools have their water supply regular-
22 ly checked.

23 331. Restaurant and other food handling establish-
24 ments are inspected - the failure of municipal authori-
25 ties to institute necessary prosecutions have lessened
26 the value of this part of the programme in some areas.

27 332. All plans for new schools are reviewed by
28 the Sanitary Engineer of the Department with particular
29 reference to site, water and sewage disposal - final
30 inspections are made also.



menace to humans, however there is a large economic loss to the farmer. Recently it has developed that the use of penicillin and other antibiotics in treating mastitis may be getting into milk supplies with subsequent danger to those sensitive to penicillin and other antibiotics.

327. The manufacture of butter, ice cream and other products from milk is under the supervision of the Department of Agriculture in association with the Department of Agriculture.

328. All public water supplies are inspected and tested by Department of Health personnel - chlorination.

It is worthy of note that 52 per cent of the population of Nova Scotia are using fluoridated water - check surveys indicate the value of this procedure in preventing dental caries in young children.

329. On request sanitary surveys and testing

of private water supplies are carried out.

330. All schools have their water supply regularly checked.

331. Restaurant and other food handling establishments are inspected - the failure of municipal authorities to institute necessary precautions have lessened the value of this part of the programme in some areas.

332. All plans for new schools are reviewed by the Sanitary Engineer of the Department with particular reference to site, water and sewage disposal - final inspections are made also.



1 333. The personnel of the Health Units are also
2 involved in many environmental sanitation projects,
3 smoke projects, smoke control, air pollution, nuisances,
4 water pollution, sewage disposal, etc.

5 334. (b) Communicable Disease Control - This
6 will be discussed under General, Venereal Disease
7 and Tuberculosis.

8
9 GENERAL

10 335. Major emphasis is placed on immunization
11 procedures for those diseases where there is a pre-
12 ventive - such as smallpox, diphtheria, whooping
13 cough, tetanus, poliomyelitis, etc.

14 336. The policy is for the Department to provide
15 preventive biologicals free to any physician making
16 the request. For public clinics the Department
17 provides everything but the physician - this is the
18 responsibility of the organizing body.

19 337. The main emphasis of the Department is on
20 the immunization of young children - usually starting
21 at the age of 3 - 4 months. It is often not realized
22 that whooping cough in the early months of life is
23 one of the greatest killers. Repeat or "booster"
24 doses at regular intervals thereafter serves to keep
25 up the level of protection.

26 338. It is strongly suggested that, except for
27 mass protection for epidemic situations that the
28 family physician should be responsible for immunization
29 procedures in any universal medical care plan,
30 especially in the pre school age child.

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will be discussed under General, Venereal Disease

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up the level of protection.

338. It is strongly suggested that, except for

family physician should be responsible for immunization

procedures in any universal medical care plan,

especially in the pre school age child.



1 339. There is a system for reporting of notifiable
2 diseases but most physicians fail to report many of their
3 communicable disease cases - so that our records of
4 incidence are far from reliable, except for the more
5 serious types such as diphtheria and poliomyelitis.
6 One disease which appears to be becoming epidemic is
7 infectious hepatitis - it is not possible to determine
8 how many cases there are in any one year.

9 340. Epidemiological investigations are carried
10 out in order to determine the source of an outbreak,
11 e.g. typhoid fever. We have a considerable file of
12 "Typhoid Carriers" - few of these cause trouble once
13 discovered and advised.

14 341. Outbreaks of disease in maternity, childrens'
15 and general hospitals are investigated.

16 342. Supplies of specific antitoxins are carried
17 by the Department for emergency use.

18 343. The practitioner is of course the cornerstone
19 of any communicable disease programme - he sees the
20 patients first, on his reports depend early measures of
21 control, he does the actual immunization whether in
22 his office or a public clinic and he carries out the
23 necessary treatment.

24 344. Largely because of immunization procedures
25 the communicable diseases appear to be well under con-
26 trol - however, there are becoming prominent several
27 communicable virus diseases for which there is yet
28 no specific preventive, such as infectious hepatitis,
29 infectious mononucleosis and others.

30 345. Outbreaks of staphylococcal and other



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344. Largely because of immunization procedures the communicable diseases appear to be well under control - however, there are becoming prominent several communicable virus diseases for which there is yet no specific preventive, such as infectious hepatitis, infectious mononucleosis and others.

345. Outbreaks of staphylococcal and other



1 infections in hospitals has been a cause of concern
2 to the Department, especially in maternity and chil-
3 dren's hospitals.

4 VENEREAL DISEASE

5 346. The present policy of the Department of
6 Public Health is to provide penicillin free to
7 physicians for the treatment of venereal disease and to
8 pay for the carrying out of the treatment. For some
9 unknown reason our expenditures on this programme are
10 far below the estimates - possibly the present one
11 shot" treatment of gonorrhoea has reduced the cost to
12 the patient so as to bring it within his means.

13 347. Syphilis, according to laboratory reports,
14 physician reports and requests for drugs and payment,
15 is at a low figure in the province especially primary
16 and secondary syphilis. There is of course a reservoir
17 of "inactive" syphilis being discovered, but in general
18 the syphilis picture is excellent - probably largely
19 due to the effectiveness of penicillin and other
20 antibiotics combined with an extensive free blood
21 testing programme. It is routine in most hospitals
22 and doctors' offices to take a blood sample which is
23 examined free of charge.

24 348. Curiously enough the above is not true of
25 geonorrhoea which is said to be on the increase in many
26 areas. In this province our figures would suggest
27 a modest increase - however as stated above we are not
28 having an increased demand for free drugs and payment
29 for treatment.

30 349. A free clinic is maintained at the Victoria

ment, especially in maternity and child-

VENEREAL DISEASE

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Public Health is to provide notification free to

physicians for the treatment of venereal disease and to

pay for the carrying out of the treatment. For some

unknown reason our expenditures on this programme are

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places. It is however as stated above we are not

having an increased demand for free drugs and payment

for treatment.

A free clinic is maintained at the Victoria



1 General Hospital Out-patient for the Halifax City area
2 - this clinic and the personnel serve as a consultant
3 centre for venereal disease for the province.

4 MATERNAL AND CHILD HEALTH

5 #%). Within the Department there is a Division
6 of Maternal and Child Health directed by a full time
7 qualified health physician and assisted by a public
8 health nurse with special training in obstetrical and
9 infant nursing and care.

10 351. An audiometer technician does hearing tests
11 in the schools.

12 352. There is also employed on a part time basis
13 obstetrical and paediatric consultants.

14 353. An obstetrical team made up of specialists
15 is supported by this Division - this team is on 24
16 hour call to deal with obstetrical difficulties in
17 any point of the province.

18 354. The Division carries out its work through
19 physicians, hospitals, public health nurses, and the
20 general public - more emphasis is now being placed on the
21 importance of good obstetrics, prenatal care, post
22 natal care, care during the first months of life,
23 nutrition (proper feeding including vitamins) and
24 early immunization.

25 355. In the school health program, the Division
26 works through the teacher and the Public Health nurses
27 to encourage good health habits including personal
28 hygiene, proper nutrition, the importance of exercise
29 and sleep, etc.

30 356. Again, through the Public Health Nursing



- this clinic and the personnel serve as a consultant centre for venereal disease for the province.

MATERNAL AND CHILD HEALTH

Within the Department there is a Division of Maternal and Child Health directed by a full time qualified health physician and assisted by a public health nurse with special training in obstetrical and infant nursing and care.

There is also employed on a part time basis obstetrical and paediatric consultants.

An obstetrical team made up of specialists is supported by this Division - this team is on 24 hour call to deal with obstetrical difficulties in any part of the province.

The Division carries out its work through physicians, hospitals, public health nurses, and the general public - more emphasis is now being placed on importance of good obstetrical, prenatal care, post natal care, care during the first months of life, nutrition (proper feeding including vitamins) and early immunization.

In the school health program, the Division works through the teacher and the Public Health nurses hygiene, proper nutrition, the importance of exercise



1 Staff child health clinics and conferences are
2 arranged - any deviation from the normal is referred
3 to the family physician.

4 357. Classes are also arranged for expectant
5 mothers.

6 358. The home visiting program is one of the
7 most important parts of the program and is carried
8 out by Public Health nurses who are provided with a
9 list of all recent births - the home is visited,
10 assistance given to the mother and child, help given
11 with feeding problems, the necessity in immunization
12 is pointed out, etc. If unusual conditions are found,
13 the mother is advised to call the family doctor.

14 359. Large numbers of copies of the Canadian
15 Mother and Child and Up the Years are distributed
16 throughout the province.

17 DENTAL HEALTH SERVICES

18 360. This important activity of the Department
19 has already been discussed under Dental Services -
20 the great handicap in this field is the shortage of
21 dentists for work in the children's program.

22 361. Two important advances have been the rela-
23 tive success of the fluoridation program (22 per cent of
24 population using fluoridated water) and the dental
25 hygienist program doing topical application of fluoride
26 in the rural areas.

27 VITAL STATISTICS SERVICE

28 362. The Division of Vital Statistics is
29 responsible for the registration of all births, deaths
30 and marriages within the province - a permanent record is

arranged - any deviation from the normal is referred

to the family physician.

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most important parts of the program and is carried

out by Public Health nurses who are provided with a

list of all recent births - the home is visited,

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is pointed out, etc. If unusual conditions are found,

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361. Two important advances have been the relief

five success of the fluoridation program (25 per cent of

population using fluoridated water) and the dental

hygienist program doing topical application of fluoride

VITAL STATISTICS SERVICE

362. The Division of Vital Statistics is

responsible for the collection and dissemination of

statistics within the province - a permanent record is



1 thus available to provide data for important statis-
2 tical requirements.

3 363. The Division provides a weekly list of all
4 births to the Health Units as well as a list of all
5 deaths from tuberculosis and other communicable
6 diseases. The records are used for cancer and other
7 research. The services of this Division are in
8 constant demand both for legal and medical purposes.

9 HEALTH EDUCATION ACTIVITIES

10 #\$. The promotion of good health habits and the
11 providing of vital health information to the public
12 are among the most important activities of a Department
13 of Health. At present all members of the Department
14 emphasize this phase of their work through home visits,
15 talks, conferences, written material and demonstra-
16 tions. The success of such programs as immunization,
17 fluoridation, nutrition, etc. depends on proper
18 health education methods.

19 365. Unfortunately trained health educators are
20 in short supply - one would expect that this would be
21 a popular field for university graduates but such is not
22 the case. Further attempts must be made to locate
23 and train suitable candidates.

24 TUBERCULOSIS CONTROL SERVICES - 1961

25 366. The following health services in respect
26 to tuberculosis are available in Nova Scotia.

27 367. 1. There is an Administrator of the
28 Tuberculosis Control Services who is a member of the
29 Department of Public Health. His headquarters is at
30 the Nova Scotia Sanatorium which he also administers

...available to provide data for important elements.

363. The Division provides a weekly list of all

births to the Health Units as well as a list of all

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367. There is an Administration of the

Tuberculosis Control Services who is a member of the

Department of Public Health. His headquarters is at

Scott's Branch which he also administers.



1 as Medical Superintendent. The administrator is
2 responsible for the general supervision of tuberculosis
3 facilities in the province, the collection of statis-
4 tics and the formulation of policy to be submitted for
5 departmental approval.

6 368. A Central Tuberculosis Index is kept by the
7 administrator and a monthly letter is sent to all
8 interested and co-operating agencies in the province
9 regarding new cases, reactivations, and "what is new"
10 in respect to treatment and prevention of tuberculosis.

11 369. 2. Treatment facilities at no charge to
12 the patient:

13 a. Nova Scotia Sanatorium 300 beds
14 (Qualified thoracic surgeons
15 on the staff conduct a chest
surgical service at this in-
stitution)

16 b. Point Edward Hospital 184 "

17 c. Halifax Health Centre 26 "

18 d. Nova Scotia Hospital
19 (tuberculosis mental cases) 45 "

20 555 beds

21 370. 3. For patients undergoing treatment or
22 convalescent treatment at home, the drugs streptomycin,
23 para aminosalicylic acid and isoniazid are provided
24 free of charge to the family physician. All other
25 anti-tuberculous drugs are available to patients in
26 tuberculosis hospitals.

27 371. 4. The Health Unit Directors and the Direc-
28 tor of Tuberculosis Control for the City of Halifax
29 are each responsible for the supervision of patients
30 undergoing treatment at home under the care of their



as Medical Superintendent. The administrator is responsible for the general supervision of tuberculosis facilities in the province, the collection of statistics and the formulation of policy to be submitted for

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371. 4. The Health Unit Directors and the Director of Tuberculosis Control for the City of Halifax are each responsible for the supervision of patients undergoing treatment at home under the care of their



1 family physicians; for the conduction of chest clinics
2 throughout the province except at Point Edward Hospital
3 and the Nova Scotia Sanatorium; for the maintenance of
4 Local Case Registers and the provision of statistics
5 regarding new cases, reactivations and deaths to be
6 transmitted to the Dominion Bureau of Statistics via the
7 office of the Administrator and for the conduction of
8 surveys and clinics for the examination of contacts and
9 also apparently healthy groups. They act in an
10 advisory capacity to the Nova Scotia Tuberculosis
11 Association.

12 372. 1945. For the detection of unsuspected cases
13 of tuberculosis entering general hospitals, fifteen
14 of our larger hospitals maintain 4 x 5 photofluoro-
15 roentgenographic units (Victoria General Hospital,
16 Halifax Infirmary, Glace Bay General Hospital, Col-
17 chester County Hospital, St. Joseph's Hospital, St.
18 Rita Hospital, City of Sydney Hospital, St. Martha's
19 Hospital, St. Elizabeth Hospital, Harbour View Hos-
20 pital, New Waterford General Hospital, Aberdeen Hospi-
21 tal, Highland View Hospital, Yarmouth General Hospital
22 and the Digby General Hospital). These units are
23 operated under the Nova Scotia Hospital Insurance
24 Commission. In addition, a number of hospitals have
25 an admission x-ray program using larger standard
26 sized films (Roseway Hospital, Camp Hill Hospital,
27 Grace Maternity Hospital, Inverness County Hospital,
28 St. Mary's Hospital in Inverness and Payzant Memorial
29 Hospital).

30 373. Unfortunately, many hospitals do not provide

family physicians; for the conduction of chest clinics throughout the province except at Point Edward Hospital and the Nova Scotia Sanatorium; for the maintenance of Local Case Registers and the provision of statistics regarding new cases, recurrences and deaths to be transmitted to the Dominion Bureau of Statistics via the office of the Administrator and for the conduction of surveys and clinics for the examination of contacts and also apparently healthy groups. They act in an advisory capacity to the Nova Scotia Tuberculosis

372. 5. For the detection of unsuspected cases

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373. Unfortunately, many hospitals do not provide



1 better than 50 to 60 per cent coverage of all eligible
2 admissions.

3 374. 6. The Halifax County Tuberculosis
4 Association maintains a tuberculin test survey team
5 in Halifax County - mainly in the City - while the
6 Nova Scotia Tuberculosis Association maintains two
7 other teams presently in Cape Breton and Yarmouth
8 Counties to carry out population surveys. Positive
9 tuberculin reactors receive free chest x-ray examina-
10 tions by means of portable x-ray units operated by the
11 staffs of the Health Units. These persons are
12 Civil Servants and are members of the Department of
13 Public Health.

14 375. 7. All deaths due to tuberculosis are re-
15 ported by the Director of Registration Services to
16 the Health Unit Director concerned so that contacts may
17 be followed up if this has not been done already. The
18 Administrator also receives a copy of the report for
19 relay to the Dominion Bureau of Statistics.

20 376. 8. All new cases found and reactivations
21 detected are reported to the Administrator by the Health
22 Unit Directors that the information may be relayed to
23 the Dominion Bureau of Statistics.

24 377. 9. Point Edward Hospital and the Nova
25 Scotia Sanatorium maintain Rehabilitation Departments
26 to provide vocational guidance, diversional and occu-
27 pational therapy, pre-vocational training and social
28 services for patients in residence. The Director of
29 Rehabilitation of the Tuberculous has his headquarters
30 at the Nova Scotia Sanatorium but makes quarterly visits

better than 50 to 60 per cent coverage of all eligible

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376. 8. All new cases found and reactivations

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services for patients in residence. The Director of

Rehabilitation of the Tuberculosis has his headquarters



1 to the other institutions for general advisory and
2 supervisory purposes.

3 378. Outside of hospital, patients needing job
4 placement are referred to special placement officers
5 of the Unemployment Insurance Commission. If special
6 training is required for them, their cases are referred
7 through the Provincial Co-Ordinator of Rehabilita-
8 tion.

9 379. The Nova Scotia Tuberculosis Association and
10 its affiliated local associations contribute to the
11 rehabilitation program by providing to patients
12 recommended loans of money or equipment to establish
13 them in a suitable employment field when feasible.

14 380. 10. Necessary Laboratory Services are
15 provided by the Nova Scotia Sanatorium, Point Edward
16 Hospital and the Provincial Public Health Laboratories.

17 381. 11. The education of the patient in
18 respect to his disease is fostered by literature pro-
19 vided by the Nova Scotia Tuberculosis Association and
20 by Health Rays Magazine which has been in continuous
21 publication since 1919.

22 382. Professional education is provided by Health
23 Rays Magazine, by the monthly newsletter which goes
24 out to the Health Unit Directors and others from the
25 Administrator, and by the Nova Scotia Thoracic Society
26 which meets once or twice a year. Health Unit Direc-
27 tors and Tuberculous Hospital staffs are encouraged
28 to attend the annual meetings of the Canadian Tuber-
29 culosis Association and like professional groups.
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12. RECOMMENDATIONS

383. The Health Unit Directors are so busy with a multitude of public health problems that they could use assistance with the tuberculosis program. It would seem desirable to make available a number of "chest clinicians" to work under the general jurisdiction of the Health Unit Directors. One Clinician could serve two to three Units and would restrict his duties to the field of tuberculosis.

FACTS AND FIGURES

384. Deaths and Death Rates: During the calendar year 1960, 33 persons died of tuberculosis in Nova Scotia for a rate of 4.6 per 100,000. This was compared to 28 deaths and a rate of 3.9 in 1959. For all Canada the rate in 1960 was 4.6 deaths per 100,000.

385. Morbidity Rates: In 1960, 234 new cases of active tuberculosis were discovered (184 respiratory and 50 non-respiratory). This represented a rate of 32 per 100,000 population.

386. During the same year, 111 known cases of inactive tuberculosis reactivated. This represented a rate of 8 per 1000 names on the tuberculosis case register.

387. The combined cases requiring to undertake treatment during the year were 345 (234 plus 111 reactivations). This compares to 423 in 1959, 373 in 1958 and 361 in 1957.

388. Case Register: On December 31, 1961, there were 13,562 names of persons with active and inactive

383. The Health Unit Directors are so busy with a multitude of public health problems that they could not seem desirable to make available a number of "chest clinicians" to work under the general jurisdiction of the Health Unit Directors. One clinician could serve two to three Units and would restrict his duties to the field of tuberculosis.

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tuberculosis on our local case registere maintained by the Health Unit Directors and the City of Halifax. Of these, 854 had active respiratory disease, 105 active non-respiratory disease, 12,167 inactive respiratory and 436 inactive non-respiratory disease.

389. Costs: The Cost of the Ruberculosis Control Services for the fiscal year ending March 31st, 1961, was in round figures, \$2,600,000. This included the proportionate cost of personnel provided by Health Units.

Tuberculinization of the Population

390. In Kings County during 1959-60, 19,747 persons were given a Heaf Tuberculin test and had the test read. 4,891 showed a positive reaction for a rate of 25 per cent and yielded eight new active cases of tuberculous disease. (Children under 5 years were not regularly tested).

391. In Hants County, there were 1,789 positive reactors out of 7,661 persons tested and read for a reaction rate of 23 per cent. One new active case was found among this group.

392. In Cape Breton, of 20,546 tests read, 6,425 or 31 per cent were positive reactors.

393. At Dayspring Municipal Hospital, of 149 patients given a Heaf Test, 68.5 per cent showed a positive reaction.

394. Without a breakdown of these figures into age groups, it is evident that out tuberculin reaction rate is in the vicinity of 25 to 30 per cent. Of course, it is highest in the older age groups.

tuberculosis on our local case registers maintained

by the Health Unit Directors and the City of Halifax.

Of these, 854 had active respiratory disease, 105 active

non-respiratory disease, 12,167 inactive respiratory

and 436 inactive non-respiratory disease.

Costs: The Cost of the Tuberculosis Control

Services for the fiscal year ending March 31st, 1961, was

in round figures, \$2,600,000. This included the pro-

portionate cost of personnel provided by Health Units.

Tuberculinization of the Population

...

were given a Heaf Tuberculin test and had the test read.

4,824 showed a positive reaction for a rate of 25 per

cent and yielded eight new active cases of tuberculosis

disease. (Children under 5 years were not regularly

tested.)

391. In Hants County, there were 1,763 positive

reactors out of 7,661 persons tested and read for a

reaction rate of 23 per cent. One new active case

was found among this group.

392. In Cape Breton, of 20,546 tests read, 6,443

or 31 per cent were positive reactors.

393. At Daypring Municipal Hospital, of 149

patients given a Heaf Test, 68.5 per cent showed a positive

reaction.

394. Without a breakdown of these figures into

age groups, it is evident that out tuberculin reaction

rate is in the vicinity of 25 to 30 per cent. Of

course, it is highest in the older age groups.



CANCER SERVICES

395. The ideal way to deal with cancer in any form is, of course, prevention; but when dealing with a disease of which the cause is unknown, the development of preventive services is not simple.

396. In a few cases we do know of substances and irritants which can apparently cause a cancer to develop, e.g. long exposure to certain aniline dyes and over exposure to radiation. In these situations preventive measures can be and are taken but the cause and prevention of the great bulk of cancer is as yet undiscovered.

397. As a result, "preventive" programs have been aimed at early discovery and early treatment. In this province intensive campaigns have been under way to inform the public regarding the signs of early cancer and to urge the public to see their physician should they find or suspect the presence of an early growth. The Press, Radio, T.V., magazines and pamphlets in addition to talks by cancer authorities are all used to further this campaign.

398. The medical profession and the Canadian Cancer Society have taken a leading part in this cancer education program - it would appear that favourable results are being achieved - doctors report seeing more early cancer cases with consequent improved hope of cure.

399. In order to assist with early diagnosis, for many years the Government has provided free pathology services for tissue examination of any specimen suspected

The ideal way to deal with cancer is by

prevention, but this is not always possible.

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ment of preventive services is not simple.

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1 of being cancer - thus there is no financial barrier
2 and the profession use this service freely.

3 400. The medical profession in association with
4 the Dalhousie Medical School arrange for refresher
5 courses in early diagnosis of cancer and so assist
6 in the improvement of the program.

7 Diagnosis and Treatment

8 401. Many cases of cancer can be diagnosed in the
9 physician's office - if laboratory specimens require
10 to be examined to complete the diagnosis, this is
11 provided free as indicated above.

12 402. Most hospitals now have improved x-ray
13 and laboratory facilities suitable for the diagnosis
14 of the majority of cases.

15 403. A major advance in the diagnosis and treat-
16 ment of cancer in this province has been the estab-
17 lishment of a Tumor Clinic at the Victoria General
18 Hospital staffed by specialists in all phases of
19 medicine and surgery. Here any person with suspected
20 cancer has made available to him or her all the diag-
21 nostic knowledge and equipment required to deal with
22 such an important matter. The services of the many
23 specialists are made available at no charge to the
24 patient - this is an important contribution by these
25 men to the cancer program in Nova Scotia.

26 404. If surgery is required, the patient may
27 arrange with his surgeon of choice or he may enter the
28 public ward services at the Victoria General and have
29 the required treatment without cost. Again this is
30 a major contribution by the staff of the Victoria



1 General Hospital to the cancer program.

2 405. If the patient so desires, after a
3 diagnosis has been made, he may return to his own
4 physician for surgical treatment - however most
5 patients elect to have any necessary procedures
6 carried out at the Victoria General Hospital.

7 406. One reason for this is the presence in the
8 Victoria General Hospital of modern radiation therapy
9 equipment - in many cases with and without surgery
10 a course of radiation therapy treatments is required.
11 At present the Victoria General is the only hospital
12 with modern radiation therapy included the Cobalt
13 60 "Bomb" and radium.

14 407. In this clinic also many of the newer
15 methods of treatment are used including the newer drugs
16 which are giving some promising results - shortage of
17 funds are at present preventing a greater use of such
18 experimental drugs which may be the answer to at
19 least some cancer problems.

20 408. The Tumour Clinic was established on the
21 basis that in order to develop the necessary equipment
22 and experienced staff there must be available patients
23 from a population of approximately one million. As
24 a result of the establishment of the clinic in Halifax
25 some patients could not afford to travel to and stay in
26 Halifax. Accordingly an agreement was made by the
27 Government with the Cancer Society by which the
28 Government guaranteed the payment of transportation
29 costs to patients with incomes of \$3,500 or less coming
30 to the clinic for diagnosis or treatment - this plan is



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been made, he may return to his own
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some patients could not afford to travel to and stay in
Halifax. Accordingly an agreement was made by the
Government with the Cancer Society by which the
Government guaranteed the payment of transportation
the clinic for diagnosis or treatment - this plan is



1 still in operation and is well accepted.

2 Research

3 409. It would appear that no major advances in
4 the control of cancer will be made until the cause or
5 causes is discovered - consequently, research in this
6 field is all important.

7 410. In Canada the Canadian Cancer Society and its
8 Research Institute play a major role in Cancer Research.
9 The Government of Nova Scotia makes available to this
10 body 10 per cent of its Cancer Control Grant amounting
11 to \$15,000 to assist in this important matter.

12 411. Further support to research is given to pro-
13 jects submitted by the staff of the Medical School -
14 this year one such project is in operation with a
15 budget of about \$12,000, this money is made available
16 to the province through federal health grants.

17
18 MENTAL HEALTH

19 412. The mental health facilities of the Province
20 of Nova Scotia can be discussed under the following four
21 headings:

- 22 A. Services provided by or assisted by the
23 Department of Public Health
- 24 B. Services provided by other agencies including
25 private practitioners
- 26 C. Mental Retardation
- 27 D. Prevention

28 A. Services provided by or assisted by the Department
29 of Public Health -

30 413. The Mental Health Division of the Department



of Public Health is responsible for the development of a mental health program for the province. This program includes the following:

1. Community Mental Health Centres
2. Hospital Services for the mentally ill
3. Other mental health services
4. Training programs
5. Research

1. Community Mental Health Centres

414. For a mental health program to be effective, it must see to it that patients can be seen in the early stages when treatment is most likely to be effective.

This means that facilities must be provided so that patients can be seen easier and competent psychiatrists should be available close to the patients' homes.

415. To accomplish this, the province has been divided into ten Mental Health Regions, each of which is to have a well-staffed Mental Health Centre. These Regions are as follows:

Cape Breton (County of Cape Breton,
Richmond, Victoria, Inverness)

Eastern Counties (Antigonish, Guysboro)

Pictou

Cobequid (Colchester, East Hants)

Cumberland

Fundy (West Hants, Kings)

Digby-Annapolis

Western (Yarmouth, Shelburne)

South Shore (Queens, Lunenburg)

Halifax

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2. Hospital Services for the mentally ill
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4. Research

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Regions are as follows:

Cape Breton (County of Cape Breton)

Copeland (Colchester, West Hants)

Digby-Annapolis

South Shore (Queens, Inverness)



1 416. Mental Health Centres have already been set
2 up in seven of these Regions, and efforts are being
3 made for their development in the remaining three.
4 Each Centre has a basic professional staff of one
5 Psychiatrist, one Clinical Psychologist, and one
6 Psychiatric Social Worker. In certain areas more
7 than the basic minimum have been provided.

8 417. The Centres are operated by local Boards of
9 Directors. The medical profession are represented
10 on all boards. Most of the financing is provided
11 through the Department of Public Health using
12 Federal Health Grant Funds. It reimburses the boards
13 for the salaries of the staff, for travel within the
14 Region, and for certain other items. The Boards
15 must find and hire the staff, are responsible for the
16 management of the Centre, and must pay for the cost
17 of the office space, supplies and some other items.
18 Approximately 90 per cent is paid by the Department
19 of Public Health, and 10 per cent is raised locally.
20 We are very satisfied with this decentralized method
21 of management.

22 418. Last year approximately 2000 patients were
23 seen in the Mental Health Centre.

24 2. Hospital Services for the mentally ill

25 419. If the mental health program is to achieve
26 its objective, facilities must be provided in the local
27 general hospitals as well as the specialized mental
28 hospitals.

29 (a) Psychiatric Services in general hospitals

30 420. The American Psychiatric Association has



1 recommended that all general hospitals of over 100
2 beds should have psychiatric services. Nova Scotia
3 has twelve general hospitals of this size if we
4 were to count the Children's Hospital in this group.
5 Eight of these hospitals have psychiatric services
6 available to them, and admit patients under psychiatric
7 supervision. Only two at the present moment, Victoria
8 General Hospital and Camp Hill Hospital, have special
9 psychiatric wards. In addition to the eight general
10 hospitals of over 100 beds, the Sanatorium at Kentville
11 has psychiatrists attached to its staff. There are also
12 five hospitals with the capacity of less than 100 beds
13 which have psychiatrists in attendance.

14 421. All of the psychiatric services in general
15 hospitals outside of the Halifax area are provided
16 by the staffs of the Community Mental Health Centres.

17 (b) Special mental hospitals

18 422. Here we include -

- 19 1. The Nova Scotia Hospital
- 20 2. The Nova Scotia Training School
- 21 3. The Municipal Mental Hospitals

22 THE NOVA SCOTIA HOSPITAL

23 423. This is the provincial active treatment mental
24 hospital. It has approximately 510 patients in resi-
25 dence at any one time. Last year, it admitted 1,300
26 patients. It has a large professional staff. At
27 the moment, there are 21.8 physicians. Of these, 13.6
28 have had post-graduate psychiatric training, 5 are
29 scheduled for such training in the near future, and
30 3.2 are doing medical work only. There are 4

were to count the Children's Hospital in this group.

Eight of these hospitals have psychiatric services available to them, and admit patients under psychiatric supervision. Only two at the present moment, Victoria General Hospital and Camp Hill Hospital, have special psychiatric wards. In addition to the eight general hospitals of over 100 beds, the Sanatorium at Kenilworth has psychiatric attached to its staff. There are also five hospitals with the capacity of less than 100 beds which have psychiatric attendance.

All of the psychiatric services in general hospital outside of the Halifax area are provided by the staffs of the Community Mental Health Centres.

(b) Special mental hospitals

Here we include -

1. The Nova Scotia Hospital
2. The Nova Scotia Training School
3. The Montserrat Mental Hospital

423. This is the provincial active treatment mental hospital. It has approximately 510 patients in residence at any one time. Last year, it admitted 1,300 patients. It has a large professional staff. At the moment, there are 21.8 physicians. Of these, 13.6 have had post-graduate psychiatric training, 5 are scheduled for such training in the near future, and 3.2 are doing medical work only. There are 4



Psychologists, 9 Social Workers, 1 Registered Occupational Therapist, 84 Registered Nurses and 237 Attendants. A number of these attendants are certified nursing attendants. There is a total of 1.3 staff members for each patient.

424. The Nova Scotia Hospital provides all forms of psychiatric treatment.

THE NOVA SCOTIA TRAINING SCHOOL

425. This Institution is noted here because in other provinces the type of patients in it are cared for in the Mental Hospital System. In Nova Scotia, it is operated by the Department of Public Welfare as will be noted later.

THE MUNICIPAL MENTAL HOSPITALS

426. These are Institutions for chronic forms of mental disorder including mental illness and mental defect. They are operated by the Municipal Governments. There are eight in all, and they care for 2,161 patients.

427. Standards for Municipal Mental Hospitals have been defined, and those hospitals which meet the standards, or agree to meet them within a reasonable time, receive assistance from the province of one-half of the net operating costs. Four such hospitals caring for 71 per cent of the total patients, are now approved Institutions. These are in Cape Breton, Halifax City, Halifax County, and Kings. Four hospitals do not meet the standards and are not approved. These are Annapolis, Cumberland, Pictou, and Lunenburg.

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428. In order to meet the standards, the Institution must have a physician in attendance on a regular basis, must have 1 Registered Nurse for every 50 patients, 1 Ward Attendant for every 6 patients, must have no overcrowding, and the standards for fire protection must meet the requirements of the Fire Marshal. The other requirements need not be discussed here.

429. The Province in addition to supporting those that meet the standards provides free tranquilizing drugs to such institutions as can use them with safety, and it pays part of the cost of providing facilities for fire protection.

3. Other Mental Health Services

430. Arrangements are being made to train the Public Health Nurses in mental health problems so that they can care more effectively for this aspect of their work.

431. A pilot project is under way for boarding out in the community certain patients now in mental hospitals who can benefit by such care. This kind of boarding out program has been employed very successfully in certain parts of Europe. The key to success is adequate supervision. We are hoping that our pilot project will be successful and that we can expand the program over all the Province.

432. The Community Mental Health Centres are participating in a rehabilitation program for patients discharged from the Nova Scotia Hospital.



4. Training Program

433. In order to support the mental health program listed above, a large number of professional staff is required. They are not easy to get. For this reason, we are supporting along with the other Atlantic Provinces training programs in psychiatry, psychiatric social work, and also provide bursaries for such staff as are agreed to work for the Mental Health Services for a specific time. Last year we trained a number of personnel including -

3 Psychiatrists

4 Clinical Psychologists

12 Psychiatric Social Workers

5. Research

434. The Mental Health Services supports two research programs in different aspects of mental health being carried on by the staff of the Departments of Psychiatry and Pediatrics, Dalhousie University.

B. Services provided by other agencies including private practitioners

455. The above lists briefly the Mental Health Services provided by or assisted by the Department of Public Health. It would be a mistake to suppose that this in fact covers the mental health services in the Province. Much is provided from private and other sources.

436. There are 9 private psychiatrists practising in the City of Halifax who in addition to seeing private patients give service to the Universities and to the



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 the Province. Much is provided from private and
 other sources.



1 Hospitals. There are two private psychiatrists in
2 Sydney. Apart from these two areas, there are no
3 psychiatrists doing private work apart from those
4 supported by the Mental Health Centres.

5 437. Universities and Colleges in the Province
6 provide certain mental health services. At Dal-
7 housie University, the Department of Psychiatry of the
8 Medical School undertakes an extensive teaching pro-
9 gram - graduate and undergraduate - and also provides
10 occasional courses in psychiatry for general practi-
11 tioners.

12 438. Dalhousie University's Department of Psycho-
13 logic provides a training program for clinical psycho-
14 logists, and its staff makes numerous contributions to
15 the mental health of the Province.

16 439. The Maritime School of Social Work has its own
17 training program, and its staff is active in many fields.

18 440. Acadia University and St. Francis Xavier
19 University also have psychological departments which
20 contribute to the mental health of the Province.

21 441. A number of welfare agencies exist which
22 contribute their share. The Department of Public
23 Welfare has many mental health services and so do the
24 Welfare and Children's Aid Societies throughout the
25 province. The Children's Aid Society of Hants County
26 is working on a boarding out program for mental patients
27 residing in that area.

28 442. Municipal Governments operate the 8 Munici-
29 pal Mental Hospitals noted earlier. Those which meet
30 the approved standards receive financial assistance



1 from the Department of Public Health. Those which
2 do not meet the standards receive no such Provincial
3 aid.

4 443. The school system provides other services.
5 A number of classes for retarded children are in
6 operation.

7 444. Many volunteer agencies are active in the
8 mental health field. Chief of these is the Canadian
9 Mental Health Association with its numerous branches
10 throughout the Province.

11 C. Mental Retardation

12 445. Children who for various reasons need in-
13 stitutional care and whose I.Q. is approximately 35 or
14 higher may be admitted to the Nova Scotia Training
15 School at Truro operated by the Department of Public
16 Welfare. This institution with 162 patients has an
17 extensive training and rehabilitation program.

18 446. Children with an I.Q. below 35 who need
19 institutional care, and all mentally retarded adults
20 needing such facilities are taken care of in the 8
21 Municipal Mental Hospitals noted in an earlier section.

22 447. All of the Community Mental Health Centres
23 provide psychiatric services for children including the
24 retarded. The Halifax Mental Health Centre for
25 Children has the most extensive facilities for this
26 purpose.

27 448. The Department of Education supports a number
28 of special classes for retarded children throughout the
29 province. There are also a number of parent groups which
30 support classes for children whose I.Q. is below that

443. The Department of Education supports a number of special classes for retarded children throughout the province. There are also a number of parent groups which support classes for children whose I.Q. is below that

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445. Municipal Mental Hospitals noted in an earlier section. needing such facilities are taken care of in the 8 institutional care, and all mentally retarded adults Children with an I.Q. below 35 who need extensive training and rehabilitation program.

446. Welfare. This institution with 162 patients has an School at Truro operated by the Department of Public higher may be admitted to the Nova Scotia Training institutional care and whose I.Q. is approximately 35 or

447. Mental Health Association with its numerous branches mental health field. One of these is the Canadian Many volunteer agencies are active in the operation.

448. A number of classes for retarded children are in The school system provides other services.



needed for the usual special or auxiliary classes.

449. There is a very active and effective Association for retarded children in the Province.

D. Prevention

450. There is no easy answer to the question what can be done to prevent mental illness in its various forms. We have no agreed upon techniques for primary prevention for most forms of mental illness.

451. We are on surer ground in dealing with secondary prevention, e.g. that the prevention of more advanced forms of illness be treated in the early stages. This can only be accomplished if good psychiatric facilities are made available close to the patient wherever he may live. Our Community Mental Health Centres widely distributed throughout the province should be an important agent in this kind of preventive program.

DIVISION OF LABORATORY SERVICES

452. The Division provides a comprehensive laboratory service (330 different tests available on routine request) to the public through the medical profession and health agencies. The facilities are located in the Pathology Institute in Halifax which has 24-hour telephone service and a continuous roster of personnel on call in all sections.

453. The laboratories have a highly qualified medical and technical staff (137) which is augmented by and cooperates with the staff of the corresponding departments of Dalhousie University.

454. The primary organization of the Division of Laboratory Services is into the specialties of

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by and cooperates with the staff of the corresponding

departments of Dalhousie University.

The primary organization of the Division of

Services is into the specialties of



1 Bacteriology, Biochemistry and Pathology.

2 455. The Laboratories have facilities for out-
3 patients referred from hospitals and from doctors'
4 offices, particularly for those tests in which it is
5 necessary that the specimen reach the laboratory with
6 minimum delay.

7 456. The Division provides the laboratory ser-
8 vices of the Victoria General Hospital, sending re-
9 ports by vacuum tube to the wards, and the same ser-
10 vices are provided by mail, public carrier and tele-
11 phone to other hospitals and to doctors' offices. Some
12 few examinations, for example well-water testing, are
13 provided to members of the public direct.

14 457. Laboratory tests are charged to hospitals at
15 cost. Consultation services are not charged.

16 458. Most services to patients of doctors in the
17 province are now performed free of charge. (Appen-
18 dices attached). The tests for which charges are
19 made are either those infrequently required for out-
20 patients or tests which are ordinarily part of the
21 clinical examination, such as the first urinalysis
22 and haemoglobin determination, which examinations are
23 not offered by the laboratories even to adjoining
24 hospitals.

25 459. The Division of Bacteriology provides services
26 in public health bacteriology and serology, in hospital
27 bacteriology and in virology.

28 460. Many of the public health examinations are
29 for detection and control of communicable disease.
30 These services are available to doctors for individual

Bacteriology, Biochemistry and Pathology.

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1 patients but are also available to hospitals and health
2 authorities for investigation of epidemics. Although
3 examinations for tuberculosis (22,726) and venereal
4 disease (64,587) have somewhat decreased in number,
5 both the number of tests offered and the number
6 requested continue to increase each year.

7 461. In clinical bacteriology (20,955) the ser-
8 vices as in other sections are increasingly required
9 by doctors for assistance in selection and control
10 of treatment and not only for diagnosis. The medical
11 staff of this section is available in consultation
12 regarding, for example, the suitability of various anti-
13 biotics in individual cases.

14 462. A number of enzyme and bacterial tests for
15 control of milk sold to the public are available to
16 municipal and provincial inspectors (14,576).

17 463. The Virology Laboratories were set up in
18 1956 by Professor C. E. Van Rooyen who is one of the
19 pioneers in this field and author of one of the
20 standard textbooks. These laboratories offer a
21 variety of diagnostic tests and have been particularly
22 concerned with the diagnosis and control of polio-
23 myelitis. In 1960, these laboratories conducted
24 the first field trial of oral poliomyelitis vaccine
25 in Canada. The virological services, including
26 consultation in the field, are available to neighbouring
27 provinces at cost.

28 464. The Division of Biochemistry offers numerous
29 tests (67,110) for chemicals, enzymes and drugs in
30 body fluids. One section of the laboratory is

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devoted to investigating simpler, faster and cheaper methods of performing existing tests, to evaluating and developing new tests, to preparing control reagents for the cooperative program of inter-laboratory standards control. The Division itself cooperates with other laboratories in Canada and in the United States in standardization of reagents.

465. The commoner biochemical tests such as blood-sugar and nitrogen are now automated so that trained technologists can devote personal attention to the more complex tests.

466. A number of tests are available to health authorities for such matters as control of fluorides in drinking water supplies.

467. The Division of Pathology is concerned primarily with examination of tissues removed at operation in hospitals throughout the province which do not have pathologists and with examination of portions of tumors and other conditions removed by doctors in their offices (15,649). This service, particularly in relation to the diagnosis of malignancy, provides further information on consultation in individual cases to surgeons and radiotherapists.

468. The Haematology section is the one most concerned with out-patient services and with tests for control of drug treatment of such diseases as coronary thrombosis as well as with primarily haematological disorders (33,440).

469. The Cytology Laboratories were organized in 1955 and provide, particularly to doctors' offices, a



devoted to investigating simpler, faster and cheaper methods of performing existing tests, to evaluating and developing new tests, to preparing control reagents for the cooperative program of inter-laboratory standards control. The Division itself cooperates with other laboratories in Canada and in the United States in standardization of reagents.

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1 service (5,394) for early diagnosis of cancer. This
2 service is now being stimulated under a Federal Health
3 Grant Project by talks to women's organizations and to
4 local medical societies.

5 470. The Autopsy Service (391) provides informa-
6 tion of value to doctors in verifying diagnoses and asses-
7 sing new forms of treatment as well as much necessary
8 statistical information on such matters as radio-active
9 fall-out up-take in this area.

10 471. As of 1st December, 1961, the Pathology
11 Institute will house the Nova Scotia Laboratories of the
12 Canadian Red Cross Blood Transfusion Service under
13 organization which will facilitate liaison with our
14 own Haematology Laboratories.

15 472. The Division operates a School for Training
16 of Laboratory Technologists leading to Registration
17 with the Canadian Society. The formal course of
18 lectures and laboratories lasts six months and is
19 followed by a year of internship. The formal course
20 is the only one offered in the province. Fifty-six
21 students are enrolled in the present first-year class;
22 fourteen of these intend to seek employment in the
23 Division but another twelve will take their interne
24 year here, the others in approved hospitals with
25 laboratories supervised by pathologists.

26 473. Technicians are trained also on the job for
27 the R.T. in Specialties and for higher degrees of the
28 C.S.L.T.

29 474. The Division provides personnel and facili-
30 ties for regular regional workshops and refresher



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1 courses for Technologists and Pathologists as well as
2 conducting standards-control surveys for the infor-
3 mation of laboratories in the province.

4 475. The Division is accredited by the Royal
5 College of Physicians and Surgeons of Canada and by the
6 American Board of Pathologists for all five years of
7 graduate training of doctors toward registration as
8 specialists in pathology and bacteriology and provides
9 such training also for shorter periods as is required
10 for the training of surgeons and other specialists.
11 Staff conferences on problem cases are held daily
12 and are open to hospital staffs and visiting
13 doctors.

14 476. Laboratories in the Nova Scotia Hospital and
15 the Nova Scotia Sanatorium are under the day to day
16 supervision of the Administrators of these hospitals.

17 (Numbers in brackets above, otherwise
18 identified, are 1960 totals of examinations performed.)

19
20 HEALTH AND NUTRITION SERVICES

21 477. Nutrition is one of the most important single
22 environmental factors affecting our well being. This
23 fact is expressed in the philosophy of the World
24 Health Organization.

25 478. Since nutrition is a major factor in overall
26 health, then any health education which neglects this
27 subject, is carrying out only part of its function.
28 The Division of Nutrition of Nova Scotia aims through
29 established programmes in professional and public
30 schools of community groups, and through consultation

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1 to institution food services to develop an under-
2 standing of the contribution of nutritionally adequate
3 foods to health.

4 479. It is generally accepted that the corner-
5 stone of good nutrition is the wise selection of
6 food. However, this ability to select is not one that
7 comes naturally, it must be taught. Therefore, the
8 Division of Nutrition has directed its education
9 efforts towards the encouragement of good eating
10 habits at all ages.

11 PRENATAL NUTRITION AND HEALTH

12 480. Studies show that good prenatal maternal
13 nutrition is beneficial to the health of both mother
14 and infant. In Nova Scotia in 1959, there were 591
15 infant deaths at birth or in the first year of life.
16 Although these deaths are not all due to the poor
17 nutritional state of the mother, yet many were
18 attributed to this cause. Over a period of 15
19 months, 46 cases of infantile scurvy were seen in
20 Halifax hospitals. The majority of these cases were
21 attributed to a deficient intake of vitamin C, be-
22 cause of parental ignorance regarding proper infant
23 feeding.

24 481. In the Health Units in the province where
25 prenatal classes are being held, the nutritionist
26 has an opportunity to talk to the mothers. Unfor-
27 tunately, many of the mothers who should be at these
28 classes do not attend. A "Nurses Guide" planned for
29 these classes, emphasizes the discussion of some phase
30 of nutrition at every class. Child Health Conferences

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Maternal and Infant Nutrition

480. Studies show that good prenatal maternal

nutrition is beneficial to the health of both mother and infant. In Nova Scotia in 1959, there were 291 infant deaths at birth or in the first year of life.

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nutritional state of the mother, yet many were

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1 are attended by the nutritionist in some Health Units.
2 These could be used to more advantage.

3 PRESCHOOL NUTRITION AND HEALTH

4 482. Food habits are formed at an early age. For
5 the most part, these are learned from parents. Thus
6 it is important that good food habits be established
7 in the home.

8 483. Iron deficiency anemia is one of the most
9 common problems in young children. In one year, 148
10 cases were seen at Children's Hospital, Halifax. The
11 cause is considered to be chiefly a lack of knowledge
12 on the part of the mother regarding iron-containing
13 foods.

14 484. The preschool age group is a difficult group
15 to reach. Efforts are made by nutritionists through
16 Home and School Associations and other adult groups,
17 the press, and through information from the schools.

18 SCHOOL NUTRITION AND HEALTH

19 485. Nutrition needs vary with the age groups.
20 For this reason, education must be continued from pri-
21 mary to end of high school. The lack of health classes
22 above grade nine makes the teaching of nutrition to
23 the remaining students difficult. Efforts are made to
24 contact these students through the physical education
25 teachers and through general school assemblies.

26 486. There is a difference between illness and
27 "radiant, buoyant" health. In our school population,
28 we have many children who are not in seriously - poor
29 physical health but who are lacking the physically
30 good characteristics we expect from good nutrition.



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1 487. The in-between snacks of sweets and nutri-
2 tionally-poor foods curb the appetite for good meals.
3 There is a relation between the consumption of these
4 sweets and the increase in dental caries.

5 488. The habit of eating a poor breakfast or no
6 breakfast at all is one requiring constant education.
7 School lunch programmes are being initiated and pro-
8 moted in every part of the province to combat the
9 problem of lunches of insufficient quantity and poor
10 food value.

11 489. The serious nutritional problem of the
12 teenage group is considered to be "underdeveloped and
13 insufficient reserve to meet stressful situations."

14 This is an age of high nutritional requirements yet
15 the habits already described plus late hours and
16 peculiar diets can result in detriment to health.
17 Overemphasis on physical appearance of adolescent
18 girls can lead to restricted and fad diets.

19 490. Nutrition teaching in health and other
20 classes in our schools is too isolated from other
21 experiences of the day. There is a need for impres-
22 sing teachers with the importance of nutrition. These
23 teachers are, in the final analysis, the connecting
24 link with the student.

25 491. In the 1960 - 61 school year, 13,920 students
26 and 390 teachers have been contacted by nutritionists.
27 The current trend is for more work with the teachers.
28 These teachers are supplied with facts and nutrition
29 materials with which to carry out effective teaching.
30 At present a series of three lectures is given to each

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1 class of students at Provincial Teachers College. If
2 possible, this should be increased in future years.

3 ADULT NUTRITION AND HEALTH

4 492. Adults eat by habit based on good preferences
5 with little concern for nutritional value. There is a
6 need to motivate them to consider nutrition.

7 493. Underweight and overweight may both be con-
8 ducive to disease and eventually to a shortened life
9 span. The regulation of food intake to meet energy
10 needs is related to good habits of eating and exer-
11 cise.

12 494. Obesity is probably the greatest nutritional
13 problem of this age group.

14 495. Adults are contacted through community organi-
15 zations but unfortunately, those individuals needing most
16 help do not attend these groups. Many of these indivi-
17 duals are from the lower-income level. The
18 nutritionist offers her assistance with food budgeting
19 and purchasing. This service needs to be developed
20 further. In most cases, there is little relation
21 between the incidence of poor food habits in the
22 schools and income levels of the homes. Therefore,
23 this does not eliminate the necessity for nutrition
24 education among adults of higher income level.

25 496. The nutritionists offer consultant assis-
26 tance to other government departments and allied pro-
27 fessions.

28 497. There is a need for continuing education of
29 the public to eat good basic foods. Efforts are
30 directed towards giving practical information on what



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1 and why good foods should be given to children, and
2 to interest young children in developing good food
3 habits for intelligent selection of food in later
4 life.

5 VOLUNTARY HEALTH AGENCY SERVICES

6 498. The number of such agencies interested in
7 health care in the province is at least 35. Their
8 interest varies from a general program such as the Red
9 Cross Society to specific diseases such as the Dia-
10 betic Association. It is not possible in a brief
11 space to describe the varied activities undertaken -
12 but their interest and influence cannot be passed
13 over.

14 499. Not only do they carry out important health
15 education programs; they also collect and make large
16 expenditures on training, e.g. the St. John's Ambu-
17 lance Association in First Aid; on treatment, e.g.
18 the Poliomyelitis Association; on provision of
19 remedial equipment, and on research.

20 500. The total expenditures in the field of
21 health are quite substantial - much of it is spent
22 on treatment and provision of drugs. If a medical
23 scheme were developed to underwrite treatment and
24 drug costs, the voluntary association would still
25 have a major place in training, public education and
26 the raising of funds for research.

27 HEALTH SERVICES BY VOLUNTARY ASSOCIATIONS FOR SPECIAL
28 CONDITIONS

29 501. Under our present system of medical care
30 there is frequently no way to assist a patient suf-
fering from certain peculiar illnesses - frequently

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499. Not only do they carry out important health education programs; they also collect and make large expenditures on training, e.g. the St. John's Ambulance Association in First Aid; on treatment, e.g. the Polio Society's Association; on provision of remedial equipment, and on research.

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501. Under our present system of medical care there is presently no way to assist a patient suf-

fering from certain peculiar illnesses - frequently



1 such cases require costly drugs or a costly diet or
2 special treatments over a long period of time. The
3 ordinary wage earner is certainly not capable of pro-
4 viding what is necessary particularly in certain ill-
5 nesses when more than one person in a family is
6 afflicted.

7 502. At this time no funds are made available by
8 the Provincial Government for such cases - occasionally
9 Municipal Government will assist - but in general no
10 public funds are available.

11 503. As a result numerous voluntary organizations
12 have developed - both to assist those afflicted and to
13 raise funds for research into the cause - at the same
14 time an educational program informs the public of
15 the situation. The medical profession have given
16 freely of their time to assist such campaigns.

17 504. It is clear from the response of the public
18 that there is intense interest in such situations;
19 further, the public are suggesting that in order to
20 ensure the best results that such cases should be assis-
21 ted out of public funds if the patient or his parents
22 are not financially able to provide the required care,
23 drugs, appliances, etc.

24 505. An attempt will be made to ascertain the
25 number of such cases and the probable cost of assis-
26 tance required together with recommendations - this will
27 be dealt with in Part II of this brief.

28 HEALTH SERVICES BY OFFICIAL AGENCIES

29 506. Department of National Health and Welfare
30 (Federal) - This Department makes available to the

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HEALTH SERVICES BY OFFICIAL AGENCIES

506. Department of National Health and Welfare (Federal) - This Department makes available to the



1 Provincial Department of Public Health approximately
2 one and one half million dollars to be used for
3 public health purposes, including training of per-
4 sonnel and research. In addition there is assistance
5 in the Hospital construction field by a further amount
6 of over a million dollars.

7 507. Consultants in various phases of health care
8 are made available to the Province on request.

9 508. In the field of Public Health Engineering
10 the Federal Department maintains an office in Truro in
11 charge of a qualified Public Health Engineer.

12 509. Another Division of this Department operates
13 a Food and Drug Laboratory in Halifax - quality and
14 quantity tests on retail products are checked in this
15 laboratory.

16 510. Field personnel also deal with food and drug
17 control under Federal Legislation.

18 511. The Health of Indians is a responsibility
19 of another Division - some 3,300 Indians receive health
20 care from this source.

21 512. Department of Agriculture (Federal) - This
22 Department takes an active part in the control of
23 nation-wide animal diseases such as bovine tuber-
24 culosis and trichinosis.

25 513. A veterinary service is provided at
26 licensed abattoirs - imported meats, vegetables and
27 other food stuffs are inspected.

28 514. There is very active co-operation between the
29 Federal and Provincial Departments of Agriculture.

30 516. Department of National Resources (Federal) -

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Federal and Provincial Departments of Agriculture.

515. Department of National Resources (Federal) -



1 This department is responsible for sanitation,
2 water supplies, etc. in National Parks, e.g. the
3 Cape Breton Highland Park.

4 517. Census and Vital Statistics (Federal) -
5 The census records are important in planning a health
6 program - the collection and distributing of census
7 figures is the responsibility of this Federal Depart-
8 ment.

9 518. Although the primary responsibility for
10 collecting vital statistics is on the Province, the
11 actual production of tables and rates is carried out
12 by this Division - it is an excellent example of co-
13 operation between a Provincial and a Federal Depart-
14 ment.

15 519. Department of Fisheries (Federal) - In a
16 Province such as Nova Scotia with a large fish indus-
17 try and the necessity of exporting much of the product
18 it is important to have high sanitary standards of
19 the product - the Federal Department of Fisheries do
20 a major job in this regard. Fish plants are inspected,
21 new methods taught - standards explained, etc. A
22 large experimental station is maintained in Halifax
23 by this Department and has produced some excellent
24 results.

25 520. Department of Veterans Affairs (Federal) -
26 This Department operates Camp Hill Hospital for
27 veterans - a large out-patient Department is provided.

28 521. In addition, a "doctor of choice" plan and
29 a "dentist of choice" plan is operated throughout
30 the Province for certain classes of veterans.

This department is responsible for sanitation.

Cape Breton Highland Park.

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522. Department of Agriculture (Provincial) -

This Department plays an important part in the health services of the province since a proper meat and milk supply depends on a healthy livestock and poultry population.

523. This department operates an Agricultural College at Truro and has representatives in all parts of the province who assist farmers with their problems.

524. A veterinary support program to assist in veterinary service throughout the province is a responsibility of this Department.

525. Certain dairy product standards such as for butter and ice cream are the responsibility also of this Department.

526. Many educational courses and demonstrations are given for the sanitary killing and handling of meat and poultry.

527. Control of animal diseases is an important part of the work, e.g. tuberculosis and brucellosis - excellent results are being obtained.

528. Department of Education (Provincial) -

This Department operates a Physical Fitness Division which assists in health programs in the school and general population.

529. Health education is an integral part of the curriculum - as discussed previously teacher training in health is an important part of the program.

The proper teaching of good health habits at an early age is most important.

530. By assisting with the school building program



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major progress is being made in providing a healthy environment for school children.

531. Nutrition teaching, demonstrations and the school lunch program are further important contributions to a health program.

532. Parent-teacher organizations, encouraged by the Department, help by discussions to clear up many misunderstandings such as the necessity for homework, physical training, discipline, etc.

533. Department of Welfare (Provincial) - There are many borderline situations between health and welfare - often a cooperative effort is the only solution. The personnel of these Departments by working together do much to find and solve health situations.

534. This Department, as noted previously, is responsible for the medical care program for Recipients of Social Assistants.

ALCOHOLISM

535. The problem of alcoholism is a serious one in Nova Scotia as indeed it is elsewhere. In estimating the number of alcoholics in any community, the best modern practice is to use the Jellenik formula based on the number of deaths from sclerosis of the liver plus 10 per cent. This method applied to Nova Scotia makes the probable number of alcoholics in the province around 6,500.

536. At the present time, there is no organized program for the treatment or rehabilitation of alcoholics on any large scale. Most general hospitals are



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1 unwilling to take alcoholics although a few are
2 treated if they are admitted under another diagnostic
3 label.

4 537. The Nova Scotia (Mental) Hospital takes a
5 number. Last year 160 were admitted. Since the
6 total number of admissions to the Nova Scotia Hospital was
7 around 1,300, this means that approximately 12 per cent
8 of all admissions were alcoholics.

9 538. There are a number of active Alcoholic
10 Anonymous groups in the province, and this association
11 is probably the most effective force for rehabilitation
12 of alcoholics that we have at present.

13 539. The Government of Nova Scotia in 1959 set up
14 a Nova Scotia Alcoholism Research Commission. The pur-
15 pose of this Commission was to look into the problem
16 and to make recommendations to the Government on a
17 program for prevention, education and rehabilitation.
18 This Commission has been very active since it has
19 been appointed, and its recommendations are now in the
20 hands of the Provincial Government. It is to be
21 hoped that an active program will be established before
22 long.

23 PROVISION OF BLOOD AND RELATED PRODUCTS

24 540. With the exception of St. Martha's Hospital,
25 Antigonish which operates its own blood bank and
26 transfusion service, the remainder of this province
27 receives these services through the Canadian Red Cross
28 Society. Donated blood is collected and processed
29 by the Society in its own laboratory - a transportation
30 service is provided - blood matching is free to the



NOVA SCOTIA HEALTH SERVICES
DEPARTMENT OF HEALTH SERVICES
NOVA SCOTIA

Abel.

537. The Nova Scotia (Mental) Hospital takes a

number. Last year 160 were admitted. Since the

total number of admissions to the Nova Scotia Hospital was

around 1,300, this means that approximately 12 per cent

of all admissions were alcoholics.

538. There are a number of active alcoholic

Anonymous groups in the province, and this association

is probably the most effective force for rehabilitation

of alcoholics that we have at present.

539. The Government of Nova Scotia in 1959 set up

a Nova Scotia Alcoholism Research Commission. The pur-

pose of this Commission was to look into the problem

and to make recommendations to the Government on a

program for the treatment of alcoholics.

This Commission has been very active since it has

been set up.

It is to be

hoped that an active program will be established before

long.

PROVISION OF BLOOD AND RELATED PRODUCTS

540. With the exception of St. Martin's Hospital,

Antigonish which operates its own blood bank and

receives these services through the Canadian Red Cross

Society. Donated blood is collected and processed

by the Society in its own laboratory - a transportation

service is provided - blood watching is free to the



1 patient - the physician devotes his time and effort in
2 giving the actual transfusions.

3 541. So that the service to the citizens is on a
4 non-pay basis as a result of cooperation between blood
5 donors, the Red Cross Society, the Provincial Govern-
6 ment which provides laboratory space and maintenance,
7 the Hospital Insurance Commission which pays for cross
8 matching, the hospitals and the physicians.

9 542. This service has been in operation for some
10 15 years - the key to the transfusion problem is of
11 course the volunteer donor - our citizens, including
12 the Armed Forces resident in the province have enabled
13 this excellent service to continue and expand.

14 543. Certain blood products such as gamma globulin
15 are also made available for use when required.

16 544. The Government is very well aware of the debt
17 it owes to the providers of this service - especially
18 the volunteer donors. Money alone is not enough to
19 cause a person to donate blood - there must be a real
20 desire to help one's neighbour - not once but repeated-
21 ly.

22 545. In its efforts to assist the Red Cross
23 Society in its campaign, new quarters for the labora-
24 tory service of the Blood Transfusion Service are
25 being provided in the Pathology Institute by the
26 Government - the space will also be maintained at the
27 expense of Government.

28 MEDICAL RESEARCH

29 546. As in many other fields, research in the
30 field of medicine is regarded as all important. Past

546. As in many other fields, research in the

expense of Government.

Government - the space will also be maintained at the being provided in the Pathology Institute by the

tory service of the Blood Transfusion Service and

Society in its campaign, new quarters for the labor-

545. In its efforts to assist the Red Cross

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the Hospital Insurance Commission which pays for cross

ment which provides laboratory space and maintenance,

donors, the Red Cross Society, the Provincial Govern-

non-pay basis as a result of cooperation between blood

541. So that the service to the citizens is on a

giving the actual transfusions.



1 and present discoveries have whetted our appetites
2 for more information, more "cures" - more miracle
3 drugs. Despite many advances there are still vast
4 unknowns in human disease - causation - cure.

5 547. In view of the past successes of research
6 it is only reasonable to expect that the cause and
7 cure of such diseases as cancer will eventually be
8 found. The more research funds available the
9 shorter the interval should be.

10 548. The Government is well aware of the importance
11 of medical research and would hope that research would
12 have an important place in any scheme of health care.
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for more information, more "cures" - more miracle
drugs. Despite many advances there are still vast
unknowns in human disease - causation - cure.

it is only reasonable to expect that the cause and
cure of such diseases as cancer will eventually be
found. The more research funds available the
shorter the interval should be.

248. The Government is well aware of the importance
of medical research and would hope that research would
have an important place in any scheme of health care.



385

APPENDIX A

NUMBER OF PHYSICIANS

REGISTERED AND RESIDING IN NOVA SCOTIA

ALSO SHOWING

SCHOOL OF GRADUATION

June 30, 1961

PHYSICIANS REGISTERED	NO.	SCHOOL OF GRADUATION		
		DALHOUSIE	OTHER CANADIAN	OTHER
ACTIVE GENERAL PRACTICE	385	290	33	62
ACTIVE SPECIALTY PRACTICE	212	137	26	49
SUB-TOTAL	597	427	59	111
TAKING GRADUATE TRAINING	56	39	3	14
ADMINISTRATIVE ET AL	66	39	7	20
FEMALES NOT IN PRACTICE	18	5	1	12
MILITARY SERVICE	37	4	15	18
RETIRED	33	24	3	6
MOVED FROM NOVA SCOTIA	2	2	0	0
TOTAL	809	540	88	181

SOURCE - REGISTRAR, PROVINCIAL MEDICAL BOARD

APPENDIX A

NUMBER OF PHYSICIANS

REGISTERED AND RESIDING IN NOVA SCOTIA

ALSO SHOWING

SCHOOL OF GRADUATION

June 30, 1961

SCHOOL OF GRADUATION				NO.	REGISTERED
OTHER	CANADIAN	DAVONSHIRE	OTHER		
11	11	20	11	52	ACTIVE GENERAL PRACTICE
12	12	181	12	181	ACTIVE SPECIALTY SERVICES
13	59	421	111	597	SUB-TOTAL
14	12	12	12	36	ADMINISTRATIVE ET AL
15	7	39	20	66	FEMALES NOT IN PRACTICE
16	1	2	12	15	MILITARY SERVICE
17	12	4	12	37	RETIRED
18	3	24	6	33	MOVED FROM NOVA SCOTIA
19	88	240	181	809	TOTAL

SOURCE - REGISTRAR, PROVINCIAL MEDICAL BOARD



DENTAL HEALTH SERVICES

APPENDIX B

DENTAL STATISTICS 1961

Ratio of dentists to population as reported by the
Canadian Dental Association.

1. Ontario	2,423	
2. British Columbia	2,426	
3. Alberta	2,977	
4. Manitoba	3,143	
5. Prince Edward Island	3,323	
6. Quebec	3,679	
7. Nova Scotia	3,689	-(Since 1951 the dental population in Nova Scotia increased by 2.1%. This is far short of general po- pulation increase which is 16.2%)
8. Saskatchewan	4,643	
9. New Brunswick	5,000	
10. Newfoundland	10,929	
Canada	3,037	

The above figures are obtained by dividing
the number of dentists registered in each province into
the total population. As there are many non effectives
in each province, these figures are all higher than
the actual ratios. In Nova Scotia in May 1961, there
were 234 dentists on the Dental Register - 158 of
these are engaged in private practice. (158:746,000
equals 4,720)

The current supply of dentists in this
province is sufficient to meet the dental needs of

DENTAL STATISTICS 1961

Ratio of dentists to population as reported by the

1	Canada	3.037
2	1. Ontario	3.183
3	2. British Columbia	2.977
4	3. Alberta	3.426
5	4. Manitoba	3.323
6	5. Saskatchewan	4.643
7	6. Nova Scotia	5.000
8	7. New Brunswick	3.037
9	8. Prince Edward Island	3.323
10	9. Newfoundland	3.183
11	10. Yukon	3.183
12	11. Northwest Territories	3.183
13	12. Nunavut	3.183
14	13. Quebec	3.183
15	14. Ontario	3.183
16	15. British Columbia	3.183
17	16. Alberta	3.183
18	17. Manitoba	3.183
19	18. Saskatchewan	3.183
20	19. Nova Scotia	3.183
21	20. New Brunswick	3.183
22	21. Prince Edward Island	3.183
23	22. Newfoundland	3.183
24	23. Yukon	3.183
25	24. Northwest Territories	3.183
26	25. Nunavut	3.183
27	26. Quebec	3.183
28	27. Ontario	3.183
29	28. British Columbia	3.183
30	29. Alberta	3.183
31	30. Manitoba	3.183
32	31. Saskatchewan	3.183
33	32. Nova Scotia	3.183
34	33. New Brunswick	3.183
35	34. Prince Edward Island	3.183
36	35. Newfoundland	3.183
37	36. Yukon	3.183
38	37. Northwest Territories	3.183
39	38. Nunavut	3.183
40	39. Quebec	3.183
41	40. Ontario	3.183
42	41. British Columbia	3.183
43	42. Alberta	3.183
44	43. Manitoba	3.183
45	44. Saskatchewan	3.183
46	45. Nova Scotia	3.183
47	46. New Brunswick	3.183
48	47. Prince Edward Island	3.183
49	48. Newfoundland	3.183
50	49. Yukon	3.183
51	50. Northwest Territories	3.183
52	51. Nunavut	3.183
53	52. Quebec	3.183
54	53. Ontario	3.183
55	54. British Columbia	3.183
56	55. Alberta	3.183
57	56. Manitoba	3.183
58	57. Saskatchewan	3.183
59	58. Nova Scotia	3.183
60	59. New Brunswick	3.183
61	60. Prince Edward Island	3.183
62	61. Newfoundland	3.183
63	62. Yukon	3.183
64	63. Northwest Territories	3.183
65	64. Nunavut	3.183
66	65. Quebec	3.183
67	66. Ontario	3.183
68	67. British Columbia	3.183
69	68. Alberta	3.183
70	69. Manitoba	3.183
71	70. Saskatchewan	3.183
72	71. Nova Scotia	3.183
73	72. New Brunswick	3.183
74	73. Prince Edward Island	3.183
75	74. Newfoundland	3.183
76	75. Yukon	3.183
77	76. Northwest Territories	3.183
78	77. Nunavut	3.183
79	78. Quebec	3.183
80	79. Ontario	3.183
81	80. British Columbia	3.183
82	81. Alberta	3.183
83	82. Manitoba	3.183
84	83. Saskatchewan	3.183
85	84. Nova Scotia	3.183
86	85. New Brunswick	3.183
87	86. Prince Edward Island	3.183
88	87. Newfoundland	3.183
89	88. Yukon	3.183
90	89. Northwest Territories	3.183
91	90. Nunavut	3.183
92	91. Quebec	3.183
93	92. Ontario	3.183
94	93. British Columbia	3.183
95	94. Alberta	3.183
96	95. Manitoba	3.183
97	96. Saskatchewan	3.183
98	97. Nova Scotia	3.183
99	98. New Brunswick	3.183
100	99. Prince Edward Island	3.183
101	100. Newfoundland	3.183

The above figures are obtained by dividing

the number of dentists registered in each province into the total population. As there are many non effectives in each province, these figures are all higher than the actual ratios. In Nova Scotia in May 1961, there were 234 dentists on the Dental Register - 128 of these are engaged in private practice. (128:746,000 equals 4.720)

The current supply of dentists in this



1 approximately 25 per cent of the population. One
2 dentist can look after comprehensive dental care
3 for 1,000 patients per year.

4 Our dental hygienists record the dental
5 examinations of approximately 20,000 rural village
6 and small town children (4-12 years of age) each year.
7 They reported that 22 per cent of children seen in 1959
8 were getting regular dental care. In 1960 the
9 figure was 23 per cent.



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They reported that 22 per cent of children seen in 1959
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examinations of approximately 20,000 rural village
Our dental hygienists record the dental



ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

1			
2			388
3	Distribution by Community Size	Number of dentists in private	
4		practice 158	
5		Dentists	
5	Metropolitan Halifax	61	39% of N.S. Total
6	Population 179,220		
7	Sydney Metropolitan Area)		
7	Population 87,324, incl.)		
8	Glance Bay)		
8	New Waterford)		
8	Sydney Mines)		
9	North Sydney)	27	17% of N.S. Total
10	New Glasgow 8		
10	Westville 1 New Glasgow area	10	
10	Pictou 1		
11	Truro 12,098	10	
12	Amherst 10,549	5	
13	<u>Towns under 10,000</u>		
14	Antigonish	4	
14	Yarmouth	4	
14	Bridgewater	4	
15	Windsor	4	
15	Kentville	4	
16	Middleton	3	
16	Liverpool	3	
16	Lunenburg	2	
17	Springhill	2	
17	Digby	2	
18	Wolfville	2	
18	<u>One dentist each</u>		
19	Cheticamp		
20	Port Hawkesbury		
20	New Germany		
21	Caledonia		
21	Chester		
21	Shelburne		
22	Annapolis		
22	Oxford		
23	Parrsboro		
23	Weymouth		
23	Meteghan	<u>11</u>	
24		158	
25			
26			
27			
28			
29			
30			



Number of dentists in private practice 128

Dentists

33% of N.S. Total

51

Population 19,220

Sydney Metropolitan Area)
(
Gloucester Bay)
New Waterford)
Sydney Mines)
North Sydney)

17% of N.S. Total

27

New Glasgow 8
Westville 1 New Glasgow area
Pictou 1

10

Total 12,098

10

Amherst 10,249

2

Population 12,000

4

4

4

4

4

3

3

2

2

2

2

One dentist each

New Germany

Caledonia

(Wester

Malapoa

Annapolis

Oxford

Windsor

Mercedan

11
128



TRAINING FACILITIES

Dalhousie Dental School at present has the facilities to graduate 25 dentists per year. Students are drawn mainly from the four Atlantic provinces.

<u>Current Registration</u>		<u>Nova Scotians</u>
1st year	18	7
2nd year	13	3
3rd year	14	7
4th year	<u>14</u>	<u>2</u>
Total Registration Sept. 1961	59	19

In addition to the above, a class in Dental Hygiene started this year at Dalhousie. Eight students (4 from Nova Scotia) are registered. Training facilities exist to graduate 12 dental hygienists per year.

Present training facilities for dentists are not being utilized to capacity, due to lack of interest in careers in dentistry and high cost.

Even if the dental school was filled each year and all the graduates stayed in the Atlantic Provinces, it would be many years before sufficient dentists were available to look after the dental needs of the population. As long as a better economic climate prevails in other provinces, new dental graduates will move to those areas.

Dalhousie Dental School at present has the

are drawn mainly from the four Atlantic provinces.

Enrollment		Total Registration	
1st year	18	1st year	18
2nd year	13	2nd year	13
3rd year	14	3rd year	14
4th year	14	4th year	14
Total Registration	59	Total Registration	59
tion Sept. 1961	59	tion Sept. 1961	59

In addition to the above, a class in Dental

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graduates will move to those areas.



DENTAL HEALTH SERVICES IN NOVA SCOTIA

FUTURE OUTLOOK

FLUORIDATION

Fluoridation of public water supplies was started in 1956 in Halifax, Dartmouth and Kentville. In 1959, Wolfville instituted fluoridation. The total water population of these four centres is approximately 164,500 or 22 per cent of the provincial population.

It does not appear likely that other provincial urban centres will avail themselves of this preventive dental measure in the near future. It is interesting to note that many of the smaller centres in Saskatchewan are starting to fluoridate their water supplies. This is assisted by a package deal whereby the provincial government will make available a substantial part of the capital cost of new communal water and sewer systems if they include fluoridation, chlorination, and sewage disposal systems. Some measure of government assistance toward the cost of installing fluoride feeders would encourage many centres not now receiving the preventive benefits of fluoridation to start fluoridation programs. Money spent in this manner would, in the end, be repaid many times over in the dental health of the children. It would be a better long-range partial solution of the dental health problem than any dental treatment scheme.

NUTRITION

There is a very direct correlation between

...the ...
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...the ...

The ...
total water population of these four centres is
approximately 184,500 or 25 per cent of the provincial

It does not appear likely that other pro-
vincial urban centres will avail themselves of this
preventive dental measure in the near future. It is
interesting to note that many of the smaller centres in

Saskatchewan are striving to eliminate their water
supply. This is related to a package deal whereby

the provincial government will make available a
substantial part of the capital cost of new community water
and sewer systems if they include fluoridation.

chlorination, and sewage disposal systems. Some
measures of government assistance toward the cost of

centres now receiving the preventive benefits of
fluoridation to assist fluoridation programs. Money

spent in this manner would, in the end, be repaid
many times over in the dental health of the children.

It would be a better long-range partial solution of
the dental health problem than any dental treatment

There is a very direct correlation between



1 nutrition and dental disease and the statement that a
2 child properly fed will not be subject to dental
3 caries is quite true. However, changing the eating
4 habits of a nation is, to say the least, extremely
5 difficult. People for the most part will eat what
6 they like rather than what is good for them. The
7 monumental task of educating people in proper dietary
8 habits and motivating them to practice these habits
9 is beyond the capabilities of our present force of
10 dentists, dental hygienists and nutritionists. All
11 of these people are working hard at this educational
12 task, but the results to date of any measurable
13 change in the incidence of tooth decay rates are
14 not encouraging.

15 SUGGESTED SHORT TERM SOLUTIONS TO IMPROVE DENTIST-
16 POPULATION RATIO

17 A committee from the Nova Scotia Dental
18 Association have presented a brief to the Honourable
19 Minister of Public Health recommending a system of
20 bursaries to assist dental students to finance the
21 cost of obtaining dental training. This scheme
22 would follow the one set up by the Newfoundland
23 government. In brief, the scheme consists of a
24 bursary of \$1,200 per year for the four years of
25 professional training. Students must agree to spend
26 four years in Newfoundland following their graduation.
27 On graduation the bursary recipient must practice for
28 two years in a location selected by the Newfoundland
29 Department of Health. At this location, equipment
30 costs up to \$3,000 are supplied by the Department
of Health, plus a monthly stipend of \$300 for half-time



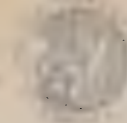
1 work on a child dental care program. The Department
2 of Health also payys \$50.00 toward rent of the office
3 plus a portion of a dental assistant's salary. The
4 dentist at the end of two years supplies his own
5 equipment and must practice in Newfoundland for two
6 more years. He is offered an hourly rate of \$10
7 to practice on the child dental care program.

8 This recommendation is now under considera-
9 tion. It might attract a limited number of students,
10 particularly those ineligible or not interested in the
11 Armed Services Professional Training Plan, which is
12 more attractive from a financial standpoint
13 (approximately \$12,000 for the four years' profes-
14 sional course with a five-year service commitment.)
15 It is worthy of a trial. At the present time, we have
16 no dentists to operate our mobile units or hospital
17 services. A bursary scheme would appear to offer a
18 solution to the current staff problem.

19 SUBSIDIZED PRACTICE

20 This would work if tied into a student
21 bursary commitment. Under present conditions there
22 are good opportunities in the larger urban centres for
23 private practice. Subsidization would have to be
24 very substantial to attract a young dentist to
25 settle in a small town.

26
27 Source: Division of Dental Health,
28 Department of Public Health
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APPENDIX C

AGRICULTURE AND HEALTH

Agriculture's interest in general health:

1. Agriculture is a basic industry for the supply of essential food products.
2. Meat and milk supply is dependent upon a healthy livestock and poultry population.
3. Several animal infections are transmissible to humans.
4. Sanitary preparation and distribution of meats and dairy products are modern requirements.
5. Programs for the control and eradication of animal diseases are under the direction of the Department of Agriculture.

Livestock and poultry, with their by-products provided a very large and important part of the food requirements of our population. The health of our livestock and poultry reflect directly or indirectly upon the quantity and quality of such essential food products.

An important function of Agriculture in the general health program is to maintain our herds and flocks in a healthy condition and to prevent the introduction of foreign diseases into our livestock and poultry. To accomplish this aim, the Federal and Provincial Departments of Agriculture have sponsored policies for the eradication of some diseases and for the control of other infections. Quarantine stations are maintained, through which imported animals must be



1 cleared, and where precautions are taken for the
2 introduction of diseases from outside of Canada.

3 Tuberculosis of cattle is a specific example
4 of a disease that has been brought under control.
5 This has been accomplished by testing and re-testing
6 of all cattle herds in Canada until at the present
7 time only a very small fraction of one per cent of
8 the cattle population give a positive reaction to the
9 tuberculin test. Originally individual herds were
10 tested on a voluntary basis, with no compensation
11 paid for reactors ordered destroyed. As the
12 effective results of the testing became apparent, the
13 policy gradually evolved into one whereby government
14 regulations made it compulsory that all cattle be
15 tuberculin tested, with payment of compensation
16 for any animals ordered slaughtered, and the thorough
17 cleaning and disinfection of infected cattle premises.
18 Re-testing of all herds is conducted periodically so
19 as to prevent tuberculosis from again becoming a
20 health menace to our cattle population, and which
21 is indirectly a health guard to the human population.

22 Brucellosis of cattle is another important
23 infectious disease which is presently actively being
24 dealt with. This disease in cattle is sometimes
25 referred to as Bang's disease. The infectious
26 organism which is responsible for Brucellosis of
27 cattle is the same infection which is the causative
28 agent of Brucellosis of the human and which is
29 commonly known as undulant fever. This relation-
30 ship of infection has to a large extent been

...ion of diseases from outside of country.

Tuberculosis of cattle is a specific example

the cattle population gave a positive reaction to the

tuberculin test. Originally individual herds were

tested on a voluntary basis, with no compensation

paid for reactions caused or treated. As time

effective results of the testing became apparent, the

policy gradually evolved into one whereby government

regulations were introduced whereby all cattle in

tuberculin tested, with payment of compensation

for any animals caused slaughtered, and the results

cleaning and disinfection of infected cattle premises

Re-testing of all herds is continued periodically as

as to prevent tuberculosis from again becoming a

health menace to our cattle population, and which

is indirectly a health gain to the human population.

Examination of cattle is another important

infectious disease which is relatively easily for

dealt with. This disease in cattle is sometimes

referred to as bang disease. The infection

organism which is the cause for Bang disease is

cattle in the same place for which in the past

agent of bacterial or the human and which is

commonly known as bacillary dysentery. While this

1 responsible for the public demand that Brucellosis
2 in cattle be controlled and thus eliminate this as a
3 possible source of human infection.

4 Agriculture has indicated its interest by
5 making available procedures whereby the cattle popu-
6 lation may be tested for Brucellosis infection and
7 having positive reactors destroyed. Testing of
8 cattle all across Canada is proceeding at a rapid rate,
9 and all of the Province of Nova Scotia has now been
10 declared a restricted area for the control of
11 Brucellosis.

12 Calfhood vaccination for the control of
13 Brucellosis is also made available to our cattle
14 raisers. This vaccination not only increases the
15 resistance of vaccinated animals against Brucellosis
16 infection, but such animals demand a premium price when
17 offered for sale, both locally and for export.

18 Mastitis, a disease especially of dairy
19 cows, interefers with the normal production of milk,
20 and as frequent causative agents may be streptococcus,
21 staphylococcus or coliform organisms, it is an animal
22 health problem and precautions are required so as to
23 provide a good quality milk for human consumption.

24 Agriculture through its Animal Pathology
25 Services and veterinarians and Dairy Branches are
26 continually working with this problem, attempting to
27 treat and control the infection and carry out inspec-
28 tion services, thus making available a wholesome milk
29 supply.

30 Meat inspection is now a public requirement

Meat inspection is now a public requirement.

tion services, thus making available a wholesome milk

treat and control the infection and carry out hygiene

continually working with this problem, attempting to

Services and veterinarians and Dairy Inspectors are

Articulate through the Animal Industry

provide a good quality milk for human consumption.

health problem and precautions are required as to

staphylococci or coliform organisms. It is an animal

and as frequent occlusive agents may be dangerous.

cow, interferes with the normal production of milk.

usually, a disease appears in the udder.

offered for sale, both locally and for export.

infection, but such animals demand a premium price when

resistance of vaccinated animals against brucellosis

raises. This vaccination not only increases the

Brucellosis is also made available to our cattle

California vaccination for the control of

certified a vaccinated area for the control of

and all of the Province of Nova Scotia has now been

cattle all across Canada is proceeding at a rapid rate.



1 for the assurance of a healthy and wholesome meat
2 supply for human consumption.

3 Meat inspection is not solely for the pur-
4 pose of detecting diseased animals offered for
5 slaughter, but as well, provides for the supervision
6 of inspection, sanitation and hygiene at the time of
7 slaughter and during the entire processing of meats
8 and meat food products.

9 Animals which appear healthy before
10 slaughter may on inspection be found to have some
11 disease condition or to carry parasitic infections
12 such as for tape worms or trichinosis. Departments
13 of Agriculture endeavour to provide an inspection
14 service so that only wholesome meat products are
15 offered for sale to the consuming public.

16 Rabies is another disease of public health
17 importance. A bite from a rabid animal may infect a
18 human or other animal. While dogs are frequently
19 involved in an outbreak of rabies, wild animals as
20 well as domestic animals are also involved.

21 Under the authority of the Animal Contagious
22 Diseases Act, the Canada Department of Agriculture
23 has the responsibility for the control of many of
24 the more serious contagious diseases of animals.

25 Provincially the local veterinarians deal
26 with the sporadic infections. In Nova Scotia under
27 the Veterinary Assistance Policy, qualified veterinary
28 service has been made available and at the present
29 time most of the counties have one or more resident
30 veterinarians.

Most inspection is not solely for the pur-

of inspection, sanitation and hygiene at the time of
laughter and during the entire processing of meat
and meat food products.

slaughter may on inspection be found to have some
disease condition or to carry zoonotic infections
such as for tape worms or trichinella. Post-mortem
of Agriculture endeavor to provide an inspection
service so that only wholesome meat products are
offered for sale to the consuming public.
Babies is another threat of public health
importance. A bite from a wild animal may infect a
human or other animal. Wild dogs are frequently
involved in an outbreak of rabies, wild animals as
well as domestic animals are also involved.

Under the authority of the Animal Contagious
Disease Act, the Canada Department of Agriculture
has the responsibility for the control of many of
the more serious contagious diseases of animals.

Providing the local veterinarians deal
with the sporadic infections. In New South Wales

services are made available and at the present
time most of the countries have one or more resident
veterinarians.



1 An Animal Pathology Laboratory is maintained
2 at the Nova Scotia Agricultural College, Truro, for
3 the purpose of assisting veterinarians and livestock
4 owners in the testing or determining of disease
5 conditions.

6 The measure of the effectiveness of
7 Agricultural Policies in the general health of our
8 country is that with healthy livestock and poultry our
9 farmers are able to supply meat and dairy products of
10 the highest quality.

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12 (Source: Department of Agriculture,
13 Provincial)
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College, London, for

where in the center of the country of disease

The measure of the effectiveness of

Agricultural Policies in the general health of the

country is that with healthy livestock and poultry the

farmers are able to supply meat and dairy products of

the highest quality.

(Source: Department of Agriculture)



HEALTH EDUCATION AND HEALTH SERVICES
IN THE PUBLIC SCHOOLS OF NOVA SCOTIA

1. Health Education in the School Program

(a) A program in health and physical education is prescribed as a compulsory part of the school program in all public schools in Grades 1 to 6. The lessons and material for instruction in health education are provided in the form of teaching guides, which are prepared by the Department of Education and supplied free to all teachers. A program of physical activities accompanies the instruction in health and in this case also the lessons and suggestions for games, exercises, etc. are provided in the form of teachers' guides supplied free to all teachers.

(b) In grades 7, 8 and 9, health and physical education are also a compulsory part of the school program. In health, a textbook is provided for each of the three grades, for the students - You're Growing Up for Grade 7, Growing Up Healthily for Grade 8, and A Sound Body for Grade 9. A teaching guide for the school health program is prepared for the use of teachers, including suggestions on the teaching of health education, physical education, and suggestions for the school lunch.

(c) Physical education in Grades 10, 11 and 12 is an optional part of the school program, but is offered in most of the high schools which are equipped with gymnasias. An extensive teaching guide, giving lists of physical activities and games and suggestions for teaching, is supplied to all teachers giving

is prescribed as a compulsory part of the school program in all public schools in Grades 1 to 8. The lessons and material for instruction in health education are provided in the form of teaching guides, which are prepared by the Department of Education and supplied free to all teachers. A program of physical activities accompanies the instruction in health and in this case also the lessons and suggestions for games, exercises, etc. are provided in the form of teachers' guides supplied free to all teachers.

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(c) Physical education in Grades 10, 11 and 12 is an optional part of the school program, but is offered in most of the high schools which are equipped with gymnasiums. An extensive teaching guide, giving ideas of physical activities and games and suggestions for teaching, is supplied to all teachers giving

1 instruction in physical education in these grades.

2 (d) The Department of Education maintains a
3 Physical Fitness Unit with a chief supervisor and
4 four assistants - two male and two female - to
5 provide supervision and advice to teachers through
6 classroom visits, institutes and instruction at the
7 Nova Scotia Summer School.

8 2. School Health Services

9 (a) Medical and dental inspection of school
10 children is provided in non-urban areas by Public Health
11 Nurses employed by the Department of Public Health.

12 (b) Medical and dental inspection of school
13 children is provided in some of the incorporated
14 towns and cities either by nurses and doctors em-
15 ployed by school boards or by qualified people such
16 as V.O.N. Nurses engaged part time by the school
17 board for this purpose.

18 (c) Some of the larger school boards, notably
19 the City of Halifax, provide medical services and/or
20 dental services to school children.

21 (d) All children entering the public schools
22 must be vaccinated for smallpox or present a certifi-
23 cate of conscientious objection from their parents.
24 Immunization for other types of children's diseases
25 is not compulsory, but it is provided to a large
26 extent through the services of the Department of
27 Public Health.

28 (e) Most of the consolidated schools in the
29 provinces provide a school lunch service. Suggestions
30 for school lunches are distributed by the Department

1 of Education, and the net cost of school lunch ser-
2 vices is included in the foundation program of educa-
3 tion for the purpose of grants from the Department
4 of Education.

5 3. School Building Services

6 (a) All sites for new school buildings and plans
7 for new school buildings must receive approval of the
8 Department of Public Health from the point of view of
9 adequate sanitation, and make reports to school boards
10 on necessary improvements and changes.

11 (c) The Department of Education, in its grants
12 to school boards, makes grants on a sliding scale,
13 in inverse proportion to the tax-paying ability of the
14 school system, toward the health and sanitary facili-
15 ties in new school buildings and toward the construc-
16 tion and installation of improved health and sanitary
17 facilities in old school buildings. In each case,
18 the grant from the Department of Education is subject
19 to the approval of these facilities and their instal-
20 lation by the Department of Public Health.

21 4. Health Services for Teachers

22 (a) A health examination, testifying to good all-
23 round health, is required of all teachers entering
24 teaching training institutions in the province.

25 (b) All teachers receiving certification from
26 outside the province must submit a report of a full
27 health examination. In each case these reports
28 are examined by officials of the Department of Public
29 Health and the Department of Education advised whether
30 or not the person should be admitted to a teacher

(a) All plans for new school buildings and plans for new school buildings must receive approval of the Department of Public Health from the point of view of adequate sanitation, and make reports to school boards on necessary improvements and changes.

(c) The Department of Education, in its grants to school boards, makes grants on a sliding scale, in inverse proportion to the tax-paying ability of the school system, toward the local and sanitary facilities in new school buildings and toward the construction and installation of approved heating and sanitary facilities in old school buildings. In each case the grant from the Department of Education is subject to the approval of these facilities and their installation by the Department of Public Health.

4. Health Services for Teachers

(a) A health examination, testifying to good all-round health, is required of all teachers entering teaching training institutions in the province.

(b) All teachers receiving certification from outside the province must submit a report of a full health examination. In each case these reports are examined by officials of the Department of Public Health and the Department of Education advised whether or not the person should be admitted to a teacher



1 training institution or receive a certificate, as the
2 case may be.

3 (c) All teachers in service must take a periodic
4 examination either in the form of a chest x-ray or
5 some similar type of examination certifying that they
6 are free from pulmonary tuberculosis. If an examina-
7 tion indicates active tuberculosis, the teacher must
8 relinquish her position and may not return to
9 teaching until certified by the Department of Public
10 Health.

11 (d) All teachers in training for elementary
12 schools receive courses of instruction in the teaching
13 of health and physical education. Refresher courses
14 are given for classroom teachers at the Nova Scotia
15 Summer School. A special three-year program is
16 offered at that school in physical education leading
17 to special certification of teachers as instructors in
18 physical education for junior and senior high school
19 grades.

20 5. Recreation Services

21 (a) The Physical Fitness Unit of the Department of
22 Education supervises organized community recreation
23 in the province. Advice, instruction and materials
24 are supplied to supervisors of recreation and other
25 similar officials employed by towns, cities and
26 municipalities or by voluntary organizations.

27 (b) The Physical Fitness Unit conducts short
28 courses for both winter and summer sports, at
29 various places throughout the province essentially
30 for the purpose of giving instruction to leaders of



1 recreational activities, but some time just for
2 individuals who wish to obtain proficiency in these
3 activities.

4 (c) The Physical Fitness Unit of the Department
5 of Education and the Department of Public Health con-
6 duct regular examination of summer camps for boys and
7 girls and assist leaders in these camps in developing
8 a balanced program of physical recreation.

9 6. Needs

10 More systematic attention should probably
11 be given to the provision of medical and dental in-
12 spection and to medical and dental services for school
13 children. At the present time this service is by no
14 means complete and the cost of these services when
15 provided by the local school authorities is not in-
16 cluded in the cost of the foundation program, toward
17 which grants are paid.

18 Source: Department of Education,
19 Nova Scotia.
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APPENDIX E

DEPARTMENT OF FISHERIES (FEDERAL)

Although the role of the Federal Department of Fisheries within the Province of Nova Scotia would not normally be regarded as a "Health Service", much of the work performed affords direct or indirect protection to the health of Nova Scotians.

Federal authority augmented by that granted under enabling Nova Scotia Fisheries legislation permits Federal employees to be active in several fields.

PRODUCTION ESTABLISHMENTS -

1. Cured Fish, salted, pickled and smoked.
2. Filleting Establishments, fresh and frozen fillets (non-C.G.S.B.)
3. General Fish Canneries
4. Lobster Canneries
5. Plants packing fresh and frozen lobster meat, scallops, shellfish shucking establishments and filleting plants participating in the Canadian Government Specifications Board programme for the production of "Canada Inspected" fishery products.

Basic operational control is maintained over all fish processing establishments within our authority and as we descend the above listing, compliance requirements become more detailed and difficult and enforcement of regulations more rigid.

Effective control is maintain over plant construction, equipment, operating methods, general sanitation, waste disposal, quality of water required for

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tion to the health of Nova Scotians.

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under enabling Nova Scotia Fisheries legislation permits

Federal employees to be active in several fields,

PRODUCTION REGULATION

1. Control of fishing effort, timing and location.

2. Licensing, catch limits, mesh and

gear (under the Food and Drug Act).

3. General Fisheries Services

4. Marine Biological Service and other research work.

5. Fisheries Research Board, including establishment

and financing of research projects in the

Canadian Government, Fisheries and Forestry Board

programme for the production of "Canada

"Productivity" factors, etc.

Basic operational control is maintained over

all fish processing establishments within our authority

and as we oversee the above listing, compliance require-

ments become more detailed and difficult and enforce-

ment of regulations more rigid

Effective control is maintained over plant con-

struction, operation, maintenance and safety

of fish processing plants, quality of water received for



1 production and/or in-plant consumption and quality
2 control over raw materials used and the final products.

3 Such effort greatly reduces the possibility
4 of Nova Scotians receiving unwholesome or otherwise
5 dangerous fishery products from industrial outlets.

6 SURVEY WORK

7 Shellfish Production Areas

8 In conjunction with the Department of National
9 Health and Welfare, a continuing programme of Public
10 Health Engineering and Bacteriological survey work is
11 conducted to determine cause and assess results of
12 sewerage pollution in shellfish growing waters. When
13 necessary, the areas are closed and policed to prevent
14 the harvesting of shellfish which if allowed to enter
15 commercial distribution circles could prove most
16 dangerous to public health.

17 SOURCE WATER SURVEYS

18 Federal Fisheries and National Health and
19 Welfare personnel conduct investigational surveys to
20 assess the quality and suitability of proposed source
21 waters intended for fish plant use. The widespread
22 contamination of our natural water resources by
23 municipal and industrial wastes presents a great pro-
24 blem. Food processing necessitates the use of great
25 volumes of pollution-free water. Our work has shown
26 it to be a relatively rare commodity.

27 PRODUCTION SURVEYS

28 Fisheries personnel conduct detailed
29 bacteriological examination of production methods and
30 production-line operating conditions. Such action

production and/or in-plant consumption and quality
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dangerous fishery products from industrial outlets.

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municipal and industrial wastes presents a great pro-
blem. Food processing necessitates the use of great
volumes of pollution-free water. Our work has shown
it to be a relatively rare commodity.

PRODUCTION SURVEYS

Fisheries personnel conduct detailed
bacteriological examination of production methods and
production line operating conditions.



1 reveals foci of contamination, makes possible their
2 elimination and results in production of safer pro-
3 ducts which have better quality, longer shelf life and
4 greater consumer acceptance.

5 PARALYTIC SHELLFISH POISONING

6 Federal Fisheries personnel through field
7 sampling and laboratory preparation of toxicity ex-
8 tracts after subsequent toxin measurement by National
9 Health and Welfare, effect a field control over
10 shellfish harvesting areas. Where shellfish are
11 affected by those naturally occurring yet lethal toxic
12 conditions, harvesting is halted and the areas are
13 "closed" and policed until toxin levels drop below the
14 danger point. Records reveal that not only serious
15 illness but death has resulted from consumption of
16 toxic shellfish. Frequency of such cases in the
17 Maritimes would be very great were it not for the
18 Federal Fisheries field control programme.

19 CANNED FISH INSPECTION

20 Federal Fish Inspection Laboratories conduct
21 detailed physical, organoleptic, chemical and bacterio-
22 logical examination of fish and fishery products whether
23 canned or preserved in any other way.

24 Basic quality control over domestic produc-
25 tion is possible through frequent examination of
26 production line samples and through voluntary submis-
27 sion by packers of production lots for quality assess-
28 ment.

29 All imported fish and fisheries products
30 are subjected to similar detailed examination and are

foot or contamination, water possible that
station and water in production of water pro-
ducts water better quality, longer shelf life and

sampling and laboratory preparation of toxicity ex-

Health and Welfare, effect a field control over
shellfish harvesting areas. Where shellfish are
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production line samples and through voluntary admis-
sion by producers of production lots for quality assess-



1 released for commercial distribution only if found to
2 be wholesome and safe for human consumption.

3 Concurrent with plant control and product
4 inspection programmes, is that of education. Much
5 has been done through illustration, demonstration and
6 persuasion to improve the production techniques,
7 handling methods and personnel hygiene; these are
8 reflected in higher quality, wholesome, final products
9 for local and distant markets.

10 STREAM POLLUTION

11 Of chief concern to federal fisheries per-
12 sonnel are those de-oxygenating and toxic wastes which
13 upon entering our waterways result in stream condi-
14 tions which are injurious or lethal to fish.

15 Waste materials from sawmills, oil refineries,
16 pulp and paper mills, food processing establishments,
17 mining operations and municipal sewage are merely a
18 few of the causes of stream pollution problems.

19 The Federal Department of Fisheries is
20 striving to put a halt to indiscriminate disposal of
21 waste materials into our lakes, streams and coastal
22 waters.

23 Success gained from fish culture and propo-
24 gation viewpoints also aid the province as a whole for
25 every reduction in the contamination load increases the
26 availability of better quality water for municipal, in-
27 dustrial and recreational use in Nova Scotia.

28 Source: Department of Fisheries
29 (Federal)
30

... only it found to ...

Governments with plant control and product
... is first of education. Much
... been done through illustration, demonstration and

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waste materials into our lakes, streams and coastal

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gation viewpoints and aid the province as a whole for
every reduction in the contamination load increases the

Quarantine and recreational use in Nova Scotia.



APPENDIX F

FOOD AND DRUG DIRECTORATE (FEDERAL)

An Outline of the Work of the Food and Drug Directorate
(Eastern Region)

The Food and Drugs Act and the Regulations thereunder are designed to protect the consumer from health hazards and frauds. Violations of both types could be found in a single commodity. For example, a meat product could be made to retain the appearance of freshness by the use of a poisonous preservative, or an important ingredient could be omitted, or reduced in quantity, in the compounding of a drug. Fortunately, these are the exceptions, rather than the rules.

For the purpose of carrying out the administration of the Food and Drug legislation, the work may be divided into two phases, Inspection and Laboratory, with the necessary clerical work for each.

Inspection duties, as the name implies, involves first the inspection of plants concerned with the production of food and drugs. No minimum standards are established under the Act for the construction of, or facilities in these plants, but they are rated according to a scale by which a Food and Drug Inspector can decide whether a plant is satisfactory, or whether improvements in construction, sanitation, or processing are required.

Food plants which come under inspection range from abattoirs, or other killing plants, which may be

An Outline of the Work of the Food and Drug Director

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1 called the basic units, to those which produce finished
 2 products, either ready to eat, or requiring cooking in
 3 the home. In addition to this, Inspectors inquire
 4 into the growing and processing of food crops, with
 5 respect to the use of chemical pesticides and herbi-
 6 cides. Drug manufactures, wholesalers, and retailers
 7 are checked periodically for the purpose of determining
 8 adequacy of controls, plant sanitation, storage
 9 facilities, compliance with mandatory date-coding of
 10 certain pharmaceuticals, and regulation of sale of
 11 restricted or controlled drugs. Import shipments
 12 of Food and drugs are examined at all ports of entry
 13 and if necessary samples are submitted to the Laboratory
 14 for examination and analysis.

15 In the laboratory, examination and analysis
 16 is carried out on all samples submitted by Inspectors.
 17 In addition to samples from the import shipments men-
 18 tioned above, samples are also submitted from domestic
 19 manufacturers. In the case of foods, from all
 20 sources, these are examined for compliance with stand-
 21 dards, and for cleanliness. Samples of food crops
 22 are examined for pesticide residues, for which toler-
 23 ances have been established. Where standards do not
 24 apply, the use of non-permitted ingredients is in-
 25 vestigated. Similarly, drug products are also
 26 analysed to determine compliance with standards, or with
 27 labelled claims.

28 The Directorate is also concerned with work
 29 for other Government Departments and Agencies, such
 30 as the chemical analysis of water, samples, particularly



... as, either ready to eat, or requiring cooking in ...
... into the growing and processing of food crops, with ...
... respect to the use of chemical pesticides and herbicides ...
... other, drug manufacturers, wholesalers, and retailers ...
... are checked periodically for the purpose of determining ...
... adequacy of controls, plant sanitation, storage ...
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... and if necessary samples are submitted to the laboratory ...
... for examination and analysis. ...
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... is carried out on all samples submitted by inspectors. ...
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...
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... sources, these are examined for compliance with standard ...
... labels, and for cleanliness. Samples of food crops ...
... are examined for pesticide residues, for which standards ...
... have been established. Where standards do not ...
... exist, the use of non-permitted ingredients is ...
... restricted. Similarly, drug producers are also ...
... analysed to determine compliance with standards, or with ...
... labelled claims. ...
... The Director is also concerned with work ...



1 for the Public Health Engineering Division, the
2 analysis of narcotic, or suspected narcotic samples
3 for the R.C.M.P., and occasional samples from other
4 Departments. Finally, the investigation of consumer
5 complaints is an important phase of Food and Drug
6 work, and these complaints take many forms, such as
7 insect-infected, filthy, or decomposed food, and on
8 occasion, drugs which do not produce the required
9 action, or are found to be in poor condition.

10 The foregoing, of necessity, merely outlines
11 the work of the Food and Drug Directorate in the
12 Eastern Region (the four Atlantic Provinces). Its
13 details and ramifications would require much more
14 extensive explanation.

15
16 Source: Food and Drug Directorate
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Sources: Food and Drug Directorate



APPENDIX G

A summary of Public Health Services provided
by the Provincial Health Units in the Province.

SCHOOL HEALTH

Nursing Services

- (1) Act as consultant to the school teacher
in school health problems.
- (2) Carry out the health inspection of school
children as follows:
 - (a) Health inspection including vision and
tuberculin testing on all children entering
school for the first time
 - (b) Examination of referrals from teacher
 - (c) Re-inspection of children found to have
health defects on previous examinations
 - (d) Rapid inspections in special cases
such as in the case of communicable disease
or skin infestation
 - (e) Vision testing in Grade VI
 - (f) Assistance to local Medical Health
Officers in respect to control of communi-
cable diseases in the school
 - (g) Assistance with Public Health teaching

Audiometric Testing Service is provided by three units
being operated at the present time in the
schools.

Nutrition Education Service

- (1) Provision of education materials
- (2) Nutrition demonstrations; i.e. white rate
experiments

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by the Provincial Health Units in the Province.

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school for the first time

(b) Examination of referrals from teacher

(c) Re-inspection of children found to have

health defects on previous examinations

(d) Rapid inspections in special cases

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or skin infestation

(e) Vision testing in Grade VI

(f) Assistance to local Medical Health

Officers in respect to control of communi-

cable diseases in the school

(g) Assistance with Public Health teaching

Audiometric Testing Service is provided by three units

being operated at the present time in the

(1) Provision of education materials

(2) Nutrition demonstrations; i.e. white rats

experiments



- (3) Teaching assistance
- (4) Furtherance of the school lunch program and the use of plain milk in the schools
- (5) Technical assistance in new school cafeteria construction
- (6) Provision of special projects for teenagers or special groups; i.e., lectures on food buying, overweight projects, etc.
- (7) Working and lecturing to:
 - (1) Allied Youth Groups
 - (2) Normal School Pupils
 - (3) Dalhousie Summer School Students
 - (4) Students at School for Public Health Nursing
 - (5) Students at Maritime School of Social Work

Dental Service

- (1) Therapeutic: A complement of three mobile clinics provide treatment services in rural areas when staff are available.
- (2) Preventive:
 - (a) Prophylaxis is provided by dentists on the mobile clinics.
 - (b) Prophylaxis is also provided for by the Dental Hygienists. There is an establishment for 8 hygienists. There are 5 on staff at the moment.



- (3) Technical assistance in new school cafeterias
- (4) Furtherance of the school lunch program and the use of plain milk in the schools
- (5) Provision of special projects for teenagers or special groups; i.e., lectures on food buying, overweight projects, etc.
- (7) Working and lecturing to:

- (1) Normal School Pupils
- (2) Baltimore Summer School Students
- (3) Students at School for Public Health
- (4) Students at Maritime School of Social

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- (b) Prophylaxis is also provided for by the Dental Hygienists. There is an establishment for 3 hygienists at the moment.



Sanitation Service

- (1) Approval of: (a) Sites for new school construction
- (b) Plans for water supply
- (c) Plans for sewage disposal
- (d) Lighting
- (e) Plumbing
- (2) Approval of renovations with respect to above
- (3) Maintenance of a Sanitary Inspection Service for all schools
- (4) Bacteriological examination of water supplies routinely
- (5) Health education by lectures and films
- (6) Consultative service

INFANT & PRE SCHOOL HEALTH

Nursing Service

- (1) Home visiting
- (2) Child Health Conferences (about 50)
- (3) Child Health Clinics (2)
- (4) Attendance at Crippled Children's Clinics and provision of follow-up after clinics

Nutritional Service

- (1) Attendance at Child Health Conferences
- (2) Consultative services on request

Dental Hygienist Service - is extended to the pre school age group.

MATERNAL HEALTH

Nursing Service

- (1) Prenatal Home Visiting
- (2) Prenatal Classes (9)



Sanitation Service

(1) Approval of: (a) Sites for new school con-

(b) Plans for water supply

(c) Plans for sewage disposal

(d) Lighting

(e) Plumbing

(2) Approval of renovations with respect to above

(3) Maintenance of a Sanitary Inspection Service

for all schools

(4) Bacteriological examination of water supplies

Public Health Service

(5) Health education by lectures and films

(6) Consultative service

INFANT & PRE-SCHOOL HEALTH

Public Health Service

(1) Home visiting

(2) Child Health Conferences (about 50)

(3) Child Health Clinics (2)

(4) Attendance at Crippled Children's Clinics

and provision of follow-up after clinics

Maternity Service

(1)

(2) Consultative service on request

Dental Hygienist Service - is extended to the pre school

age group.

PRENATAL HEALTH

Nursing Service

(1) Prenatal Home Visiting

(2) Prenatal Classes (2)



(3) Prenatal guide is available to V.O.N. and city
nurses, doctors and hospitals

(4) Post natal visiting.

Nutritionist Service

Attendance at Prenatal classes.

COMMUNICABLE DISEASE CONTROL

(a) Tuberculosis case finding:

- (1) Tuberculin Surveys
- (2) x-Ray Clinics
- (3) x-rays - local hospitals
- (4) Follow-up of contacts
- (5) Rehabilitation of cases
- (6) Consultation
- (7) Therapy

(b) Epidemiological studies when necessary; i.e. Typhoid

(c) Immunization - Emphasis is placed on early infant

immunization for Diptheria, Pertussis,
Tetanus, Polio and Smallpox by

- (a) Family physician
- (b) Community clinics

Reinforcing immunization is available through
the above channels.

(d) In Venereal Disease the Department pays fees for
service in the treatment of venereal disease. Follow
up of contacts is also provided.

PROVISION OF DRUGS

- (1) Gamma Globulin
- (2) Diabetic Drugs
- (3) Tuberculosis Drugs



THE STATE OF NEW YORK, DEPARTMENT OF HEALTH, DIVISION OF PREVENTIVE MEDICINE, BUREAU OF TUBERCULOSIS AND VENEREAL DISEASES

nurses, doctors and hospitals

(1) General Practice

PREVENTIVE MEDICINE

Attendance at Prenatal classes.

COMMUNICABLE DISEASE CONTROL

(a) Tuberculosis case finding:

(1) General Practice

(2) x-Ray Clinics

(3) x-rays - local hospitals

(4) Follow-up of contacts

(5) Rehabilitation of cases

(6) Consultation

(7) Therapy

(b) Epidemiological studies when necessary; i.e. Typhoid

(c) Immunization - Diphtheria is placed on early infant

immunization for Diphtheria, Pertussis,

Tetanus, Polio and Smallpox by

(a) Family physician

(b) Community clinics

Reinforcing immunization is available through

the above channels.

(d) In Venereal Disease the Department pays fees for

service in the treatment of venereal disease. Follow

up of contacts is also provided.

PROVISION OF DRUGS

(1) General Practice

(2) Diabetic Drugs

(3) Tuberculous Drugs



(4) Antigens

(5) Antitoxins (at cost price)

PUBLIC HEALTH EDUCATION

Every phase of public health involves public or individual education. Mass media is used in special projects. All members of staff speak to community groups and agencies on request. Education material, special diet information and food budgeting service, are provided on request. Certain staff attend folk schools in a consultative capacity in co-operation with the Department of Adult Education.

ENVIRONMENTAL HEALTH

MILK

(1) Administration of the Nova Scotia Milk Regulations in respect to pasteurized and raw milk.

(2) Provision of inspection, sampling and laboratory service for pasteurized and raw milk processing.

(3) Provision of consultative service and quality control for milk processing plants; i.e., temperature, resazurin, off-flavour, etc.

(4) Recommendation for licensing of milk producers.

(5) Regular inspection, consultation and Technical assistance to producers.

WATER

(a) Public (1) Regular inspection, consultation, technical assistance and bacteriological examination.

(2) Antitoxins (at cost price)

Every phase of public health involves public or individual education. Mass media is used in special projects. All members of staff speak to community groups and agencies on request. Education material, special diet information and food budgeting service, are provided on request. Certain staff attend folk schools in a consultative capacity in co-operation with the Department of Adult Education.

ENVIRONMENTAL HEALTH

MILK

- (1) Administration of the Nova Scotia Milk Regulations in respect to pasteurized and raw milk.
- (2) Provision of inspection, sampling and laboratory service for pasteurized and raw milk products.
- (3) Provision of consultative service and quality control for milk processing plants, i.e., farm.
- (4) Recommendation for licensing of milk.
- (5) Regular inspection, consultation and technical assistance to producers.

WATER

Technical assistance and bacteriological



- (2) Approval of plans for new
installations and extensions.
(b) Private. As above on request.
(c) Surveys.

SEWAGE DISPOSAL

- (a) Public (1) Regular inspection, consultation,
technical assistance and B.O.D. estimations.
(2) Approval of plans for new instal-
lations and extensions.
(b) Private. As above on request.
(c) Surveys.

HOUSING

Where regulations exist or when a request
is received, consultation and technical assistance
is provided in matters concerning water, sewage dis-
posal, etc.

EATING ESTABLISHMENTS

An inspection service is provided where
municipalities have a restaurant bylaw.

TOURIST ACCOMMODATION

Cooperation with the Department of Trade and
Industry in matters of sanitation in the above accom-
modation.

MISCELLANEOUS SERVICES FOR:

Slaughter houses	nuisances	rodent control
Fish plants	food shops	insect control
Bakeshops	refuse disposal, etc.	

INSTITUTIONAL HEALTH

- (1) Tuberculin surveys for county homes and
county hospitals.



(2) Approval of plans for new

installations and extensions.

(d) Private. As above on request.

(a) Public (1) Regular inspection, consultation,

technical assistance and B.O.D. estimations.

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Where regulations exist or when a request

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TOURIST ACCOMMODATION

Cooperation with the Department of Trade and

Industry in matters of sanitation in the above accom-

MISCELLANEOUS SERVICES FOR:

fish plants food shops insect control

Bakshops refuse disposal, etc.

INSTITUTIONAL HEALTH

(1) Tuberculin surveys for country homes and

county hospitals.



- (2) Nutrition course for institutional cooks
- (3) Nutrition inspection and consultation services to small general hospitals, municipal homes and hospitals, child caring institutions, summer camps, etc.
- (4) "Calling all Cooks" booklet distributed every two months to cooks in the above institutions.

REHABILITATION

- (1) Provision of medical and vocational assessment
- (2) Referral to Vocational Training services of Department of Education.
- (3) Referral to Job Placement Service of National Employment Service
- (4) Provision of a continuous counselling service in the field.



(2) Nutrition survey for institutional co-
(3) Nutrition inspection and consultation
services to small general hospitals, municipal homes
and similar institutions, etc.
(4) "Baking all Cooks" booklet distributed
every two months to cooks in the above institutions.

REMARKS:

- (1) Provision of medical and vocational assessment
- (2) Referral to Vocational Training services of
Department of Education.
- (3) Referral to Job Placement Service of
National Employment Service
- (4) Provision of a continuous counselling
service in the field.



APPENDIX H

DIVISION OF PUBLIC HEALTH NURSING

Health Care Services of Division of Public Health Nurses

Staff: 1. Director of Public Health Nurses

2. 8 Nursing Supervisors

3. 72 Public Health Nurses

The public health nurse is a qualified nurse with special training in public health. Her duties include all phases of a generalized public health program. The public health nurse works under a supervisor who is a qualified public health nurse with a university course in advanced public health administration and supervision.

A. Services in Tuberculosis Program

1. Assists in conduct of tuberculosis clinic

(a) Initiates clinic case record

(b) Supplies containers for sputum

test and does tuberculin tests as required.

2. Home visits are made after discussion with family doctors for new cases, for contacts, for convalescent cases, and for supervision and guidance to cases on home treatment and to delinquents from treatment and surveillance.

3. Does tuberculin surveys under instruction of Health Unit Directors.

B. Services Rendered in School Health Program by Public Health Nurses

1. Does health inspection on all children entering school for the first time.

2. Examines children referred by teacher in



Director of Public Health Nurses

2. 6 Nursing Supervisors

3. 72 Public Health Nurses

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with special training in public health. Her duties

include all phases of a generalized public health pro-

gram who is a qualified public health nurse with a

university course in advanced public health adminis-

tration and supervision.

Services in Tuberculosis Program

1. Assist in conduct of tuberculosis clinic

(a) Interview clinic case record

(b) Supply case records for apertures

test and does tuberculin tests as required.

2. Home visits are made after diagnosis

with family doctors for new cases, for contacts, for

for supervision and guidance

to cases on home treatment and to delinquents from

treatment and surveillance.

of Health Unit Director

B. Services Rendered in School Health Program by

1. Does health inspection on all children

entering school for the first time.

2. Examines children referred by teacher in



1 order to detect defects and initiate remedial action
2 by informing parents.

3 3. Gives consultative guidance to school
4 authorities in problems relating to communicable disease
5 control and carries out orders of M.O.H. in respect to
6 these diseases.

7 4. Does vision tests on Grade 5 children.

8 5. Checks immunization status of school-age
9 children, and cooperates in the organization of immuni-
10 zation clinics.

11 6. Assists teacher with public health
12 teaching in a consultative capacity.

13 7. The Public Health nurse has the respon-
14 sibility to see that school records required by the
15 Department of Health are completed and makes avail-
16 able information for school records.

17 C. Immunization Clinics

18 Public Health nurses assist in the organization
19 and conduct of immunization clinics and are responsible
20 for clinic supplies and records. While it is the
21 responsibility of the community to organize the clinics,
22 the nurse gives assistance and she instructs volunteers
23 in their duties.

24 D. She assists in the conduct and organization
25 of Child Health Conference matters which come under her
26 sphere of activities.

27 E. Prenatal instruction is given in the home and
28 in special classes under the direction of the Health
29 Unit Director.

30 F. She assists various voluntary societies:

order to detect defects and initiate remedial action

3.

Responsible in programs relating to communicable disease control and carries out orders of M.O.H. in respect to these diseases.

4. Does vision tests on Grade 5 children.

5. Checks immunization status of school-age children, and cooperates in the organization of immunization clinics.

teaching in a consultative capacity.

7. The Public Health nurse has the respon-

sibility to see that school records required by the Department of Health are completed and make avail-

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and conduct of immunization clinics and are responsible

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the nurse gives assistance and the structure volunteers in their duties.

D. She assists in the conduct and organization of Child Health Conference matters which come under her

E. Prenatal instruction is given in the home and

in special classes under the direction of the Health

Unit I

R.



1. Crippled Children's Society.

Names of crippled children are reported to the health units. The nurse gives assistance at clinics organized by the Nova Scotia Crippled Children's Society. Liaison with the family and with the physician is carried on by the public health nurses and plays an important part in promoting the Crippled Children's program.

2. She does follow-up work for the tumor clinic under the direction of the Health Unit Director.

3. To various agencies such as the Red Cross, V.O.N., Children's Air Society, etc., the nurse gives consultative assistance.

G. Other Miscellaneous Activities:

In the home visiting program, the nurse has many opportunities to render effective health service by giving instruction and assistance according to the indications encountered, which may concern one or more of the following:

- (a) Infant health
- (b) Tuberculosis instruction
- (c) Communicable disease control
- (d) Nutrition
- (e) Accident prevention
- (f) Instruction and care for the aged or chronically ill.

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many opportunities to render effective health service

by giving instruction and assistance according to the

indications encountered, which may concern one or more

of the following:

- (a) Infant health
- (b) Tuberculous infection
- (c) Communicable disease control
- (d) Accident prevention
- (e) Instruction and care for the aged or



HEALTH CARE SERVICES OF CHILD & MATERNAL HEALTH AND
COMMUNICABLE DISEASE
CONTROL

- Staff:
1. Director
 2. Nursing Consultant
 3. Audiometrist
 4. Obstetrical Consultant (Part-time)
 5. Paediatric Consultant (Part-time)

A. Child and Maternal Health

Services:

1. Consultative services and assistance is given to physicians, nurses, and hospitals in matters pertaining to prenatal, natal, and post-natal care, to ensure that infants, pre-school, and school children have the best public health care.

2. A Nursing Consultant service is available to general hospitals through the Nova Scotia Hospital Insurance Commission, and to nurses in general in order to improve obstetrical and infant care.

3. The audiometrist does hearing tests on children in grades one to nine. Parents are advised of difficulties.

4. Obstetrical team: A team of specialists is available on an emergency basis for any part of the province to deal with an obstetrical complication which requires special assistance that is not available locally. It sponsors special courses for instruction of nurses in various phases of infant and maternal care.

B. Communicable Disease Control

A consultative service is available for

HEALTH CARE SERVICES IN CHILD & MATERNAL HEALTH AND
COMMUNICABLE DISEASES

2. Nursing Consultant

3. Audiometrist

4. Obstetrical Consultant (Part-time)

Child and Maternal Health

Services:

1. Consultative services and assistance is

given to physicians, nurses, and hospitals in matters

pertaining to prenatal, natal, and post-natal care,

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is available on an emergency basis for any part of

the province to deal with an obstetrical complication

which requires special assistance that is not avail-

able locally. It sponsors special courses for in-

struction of nurses in various phases of infant and

maternal care.

Communicable Disease Control

A consultative service is available for



1 physicians in any part of the province to assist them in
2 dealing with problems concerning the prevention and
3 treatment of communicable diseases.

4 POLICY DESCRIPTION OF BIOLOGICALS

5 Certain biological products are issued to
6 physicians in the Province of Nova Scotia through the
7 Health Unit Directors free of charge providing the
8 physician signs a voucher indicating that these pro-
9 ducts will be administered to the public at a reduced
10 rate or free of charge. Otherwise, the physician can
11 pay a fixed rate for these products which include:

- 12 1. Smallpox vaccine
- 13 2. Diphtheria toxoid
- 14 3. Tetanus toxoid
- 15 4. Diphtheria and Tetanus toxoid combined
- 16 5. Diphtheria, pertussis, tetanus toxoid, and
17 polio vaccine combined
- 18 6. Diphtheria with tetanus combined with
19 polio vaccine
- 20 7. Plain polio vaccine is kept on hand for
21 issue on voucher only. This product is not
22 for sale.

23 ANTI-TOXINS AND VACCINES

24 Certain anti-toxins are kept in stock.
25 These products are only issued on a sale basis because
26 they are used for therapy rather than for prevention.
27 The stock includes diphtheria anti-toxin and tetanux
28 anti-toxin. A small supply of anti-rabies vaccine
29 and rabies-immune serum is available for issue through
30 Health Unit Directors on consultation.



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physicians in the Province of Nova Scotia through the

Health Unit Director's office of charge providing the

physician signs a voucher indicating that these pro-

ducts will be administered to the public at a reduced

pay a fixed rate for these products which include

2. Diphtheria toxoid

4. Diphtheria and Tetanus toxoids combined

5. Diphtheria, pertussis, tetanus toxoids, and

polio vaccine combined

6. Diphtheria with tetanus combined with

7. Plain polio vaccine is kept on hand for

issue on voucher only. This product is not

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These products are only issued on a sale basis because

they are used for therapy rather than for prevention.

The stock includes diphtheria anti-toxin and tetanus

anti-toxin. A small supply of anti-rabies vaccine

and rabies-immune serum is available for issue through

Health Unit Directors on consultation.



1 GAMMAGLOBULIN

2 Gammaglobulin is available in limited
3 quantities through the Director of Health Units for pre-
4 ention of:

- 5 (a) Hepatitis in contact
6 (b) Measles in contact
7 (c) German measles in expectant mothers
8 (d) For treatment of hypogammaglobulinemia

9 VENERAL DISEASE POLICY

10 The Department of Public Health offers a
11 consultative service in the diagnosis and treatment
12 of venereal disease.

13 (a) V.D. Syphilis - the Department of
14 Public Health will pay physicians in the Province of
15 Nova Scotia for treating a case of syphilis and will
16 supply penicillin free of charge providing minimum
17 policy requirements of the Department are met to
18 ensure adequate investigation, treatment, and case-
19 finding. No fee for treatment is allowed in Halifax
20 City, where free treatments can be obtained through
21 the Victoria General Hospital Out-patient Department.

22 (b) V.D. Gonorrhoea - The Department of
23 Public Health will pay for treatment of V.D. Gonorrhoea
24 according to the Department of Public Health schedule
25 providing the case is reported, investigated, and
26 treated in the manner prescribed on the recommen-
27 dation of the Director of the Health Unit. Examina-
28 tion of contacts is paid for by the Department of
29 Health; however, in the city of Halifax, treatment and
30 contact investigation is available through the Victoria

Section 2:

- (a) Hepatitis in contact
- (b) Measles in contact
- (c) German measles in contact
- (d) For treatment of hypogonadism

The Department of Public Health offers a
consultative service in the diagnosis and treatment
of venereal diseases

(a) V.D. Syphilis - The Department of
Public Health will pay physicians in the Province of
Nova Scotia for treating a case of syphilis and will
supply penicillin free of charge providing minimum
policy requirements of the Department are met to
ensure adequate investigation, treatment, and case-
finding. No fee for treatment is allowed in Halifax
City, where free treatment can be obtained through

(b) V.D. Gonorrhea - The Department of
Public Health will pay for treatment of V.D. Gonorrhea
according to the Department of Public Health schedule
providing the case is reported, investigated, and
treated in the manner prescribed on the schedule.
The Director of the Health Unit
tion or consult is paid for by the Department of
Health; however, in the city of Halifax, treatment and
contact investigation is available through the Victoria



1 General Hospital Out-patient Department and no charges
2 are accepted for payment by the Department for treat-
3 ment done outside of the clinic.

4 Diagnostic laboratory tests for V.D.S. and
5 V.D.G. (ophthalmia neonatorum) in the eyes of new-born
6 infants.

7 HEALTH CARE SERVICES - DIVISION OF NUTRITION

8 The nutrition service is based on an
9 educational program designed to increase public awareness
10 and interest in the value of nutrition and to promote
11 wiser food selection and better utilization so that
12 the public will obtain maximum benefit from food ex-
13 penditures.

14 Staff: 1. Director
15 2. Assistant Director
16 3. Six nutritionists

17 CONSULTANT NUTRITION SERVICE to schools as
18 arranged with the Department of Education. Services
19 include consultation with teachers, demonstrations,
20 class instruction, distribution of literature, pro-
21 motion of school lunch, and to give recommendations re-
22 garding school lunch, the aim being to improve health
23 by advocating people to appreciate the value of nu-
24 trition and to assist them in obtaining the necessary
25 foods.

26 A consultant nutrition service is given to
27 various community groups, such as Home and School
28 voluntary organizations, service clubs, and welfare
29 agencies. Various educational methods are employed
30 which vary according to the needs encountered.

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are accepted for payment by the Department for treat-
ment done outside of the clinic.

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CONSULTANT NUTRITION SERVICE TO SCHOOLS

include consultation with teachers, demonstrations,
class instruction, distribution of literature, pro-
motion of school lunch, and to give recommendations re-
garding school lunch, the aim being to improve nutri-
tion and to assist them in obtaining the necessary
by educating people to appreciate the value of nu-

A consultant nutrition service is given to

various community groups, such as Home and School
voluntary organizations, service clubs, and well-



A consultant food service is given to various institutions:

- (a) General Hospitals
- (b) Municipal Hospitals
- (c) Municipal Homes
- (d) Child Caring Institutions
- (e) To other institutions on request.

SERVICE TO SUMMER CAMPS, such as Y.W.C.A., Boy Scouts and church camps. The service includes instruction to directors prior to camp time and when possible a visit to camp during operation. Emphasis is placed on food selection and preparation.

Food Pricing Services is provided to municipal authorities, official and voluntary agencies.

Special Diet Service Assistance given to individuals at request of family physician.

DENTAL HEALTH SERVICES

- Staff:
1. Director
 2. Staff Dentists
 3. Mobile Dental Health Units
 4. Dental Hygienists

The function of this Division is to promote a program for better dental health in the Province of Nova Scotia. The present staff consists of a dentist-director, and five dental hygienists. The three mobile dental units are presently idle because of the shortage of dentists. There is a very good prospect of having two mobile units in the field before the end of this year.

A constant food service is given to

institutions:

- (a) To other institutions on request.
- (b) Child Caring Institutions
- (c) SERVICE TO SUMMER CAMPS, such as Y.W.C.A.,

Boy Scouts and church camps. The service includes instruction to directors prior to camp time and when possible a visit to camp during operation. Emphasis is placed on food selection and preparation. Food pricing services is provided to municipal

Special Diet Service assistance given to

individuals at request of family physician.

2. Staff Dentists

3. Mobile Dental Health Units

4. Dental Hygienists

The function of this Division is to promote

a program for better dental health in the Province of

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dental-director, and five dental hygienists. The

three mobile dental units are presently idle because

of the shortage of dentists. There is a very good prospect

of having two mobile units in the field before

the end of this year.



1 HEALTH CARE SERVICES OF MOBILE DENTAL UNITS

2 The Mobile Dental Unit brings prophylactic
3 services to children under twelve years of age who
4 live in areas not serviced by a dentist. The service
5 is designed to show the value of dental services.
6 The service consists mainly of extractions and fillings.
7 With current staff shortages, it is mostly an emergency
8 service.

9 HEALTH CARE SERVICES OF THE DENTAL HYGIENIST

10 The primary purpose of the dental hygienist
11 service is to educate children to appreciate the value
12 of good dental health and to instruct them in care of
13 the teeth. Dental examinations are conducted and
14 topical fluoride applications are given. These
15 services are made available in all counties excluding
16 towns and cities to children up to seven years of age.
17 These clinics must be sponsored by a voluntary
18 organization such as a home and school group, and there
19 must be a minimum of four days' work before services
20 can be given.

21 HEALTH CARE SERVICES - ENVIRONMENTAL HYGIENE
22 DIVISION

- 23 Staff: 1. Director
24 2. Assistant Director
25 3. Radiation Inspection Officer
26 4. Radiation Safety Officer
27 5. Sanitary Inspectors

28 A consultative and field service is given
29 in matters pertaining to water, milk, sewage control,
30 restaurant, camp, school sanitation and problems which



HEALTH CARE SERVICES OF THE DENTAL HYGIENIST

The primary purpose of the dental hygienist service is to educate children to appreciate the value of good dental health and to instruct them in care of the teeth. Dental examinations are conducted and topical fluoride applications are given. These services are made available in all counties excluding towns and cities to children up to seven years of age. These clinics must be sponsored by a voluntary organization such as a home and school group, and there must be a minimum of four days' work before services can be given.

HEALTH CARE SERVICES - ENVIRONMENTAL HYGIENE DIVISION

- | | |
|--------|------------------------------------|
| Staff: | 1. Director |
| | 2. Assistant Director |
| | 3. Registration Inspection Officer |
| | 4. Sanitary Inspectors |

A consultation and field service is given in matters pertaining to water, milk, sewage disposal, restaurant, camp, school sanitation and problems which



1 concern food control. There is a special consul-
2 tative service in industrial hygiene.

3 SANITATION FIELD SERVICES

4 1. Water

5 (a) Private water supplies are examined
6 on request or on survey.

7 (b) Municipal water supplies, if chlori-
8 nated, are examined twice weekly or if un-
9 treated then once a fortnight.

10 (c) School Water Supplies - if enrolment
11 is over 100, once a month. If under 100,
12 once a quarter or as otherwise requested by
13 Health Unit Director. Orthotoludin tests
14 are carried out periodically as directed.

15 2. Milk Plant Inspection

16 (a) Inspection of pasteurization plants
17 operation and equipment.

18 (b) Sampling service.

19 (c) Resazurin testing plants with over
20 1,500 quarts production daily do their
21 own testing. In smaller plants, sanitary
22 inspectors carry out resazurin tests to
23 determine the bacterial quality of milk.

24 3. Farm Inspection

25 Farm visits are made on a routine basis to
26 assist the farmer with any problems he may have in
27 the production of milk. Special farm visits are made
28 whenever problems are encountered during pasteuriza-
29 tion plant survey work such as for sediment tests
30 and for resazurin tests.



WATER SUPPLY SERVICES

(a) Private water supplies are examined

on request or on survey.

(b) Municipal water supplies, if chlori-

nated, are examined twice weekly or if un-

treated then once a fortnight.

(c) School Water Supplies - If enrolment

is over 100, once a month. If under 100,

once a quarter or as otherwise requested by

are carried out periodically as directed.

2. Milk Plant Inspection

(a) Inspection of pasteurization plant

operation and equipment.

(b) Sampling services.

(c) Reservoir testing plants with over

2,500 quarts production daily to their

own testing. In smaller plants, sanitary

inspectors carry out reservoir tests to

determine the bacteriological quality of milk.

Farm visits are made on a routine basis to

assist the farmer with any problems he may have in

the production of milk. Special farm visits are made

4. SCHOOL SANITATION

Periodic inspections of lighting, ventilation, water, sewage, and general maintenance are carried out.

New School Inspection Assistance is given in the selection of sites for new schools. There is also a final inspection of water and sewage facilities to ensure that approved plans were properly carried out. Similar services are given to assist in school renovations.

5. OTHER FIELD SERVICES

Services are being developed for the inspection and control of x-ray and radiation devices, the purpose being to protect the operators and the persons who might be associated or affected by such activities.

HEALTH CARE SERVICES - DIVISION OF REHABILITATION

Staff: 1. Co-ordinator of Rehabilitation

2. Three rehabilitation counsellors

COUNSELLING SERVICE

The aim of this Division is to promote rehabilitation in the Province of Nova Scotia. This is done mainly through consultation and assistance to interested groups and by a program of coordination with the purpose of making existing facilities more effective.

The counselling service processes referrals of handicapped persons who require rehabilitation services. Requests come from doctors, hospitals,

water, sewage, and general maintenance are

New School Inspection Assistance is given

in the selection of sites for new schools. There is also a final inspection of water and sewage facilities to ensure that approved plans were properly carried out. Similar services are given to existing schools.

Services are being developed for the inspection and control of x-ray and radium facilities. The purpose being to protect the operators and the persons who might be associated or affected by such activity.

also.

HEALTH CARE SERVICES - DIVISION OF PUBLIC HEALTH

1. Co-ordinator of Rehabilitation
2. Public Rehabilitation Committee

The aim of this Division is to promote rehabilitation in the Province of New South Wales. This is done mainly through consultation and assistance to interested groups and by a program of coordination with the purpose of making existing facilities more

services. Requests come from doctors, hospitals,



1 clinics, voluntary agencies, and public service
2 agencies.

3 REHABILITATION PROJECTS

4 (a) Under Project 602-12-1, the persons
5 selected for further rehabilitation services are
6 examined by the Rehabilitation Assessment Team, which
7 consists of two doctors, a vocational counsellor, a
8 training specialist, an employment specialist, and the
9 Co-ordinator. There is also provision for special
10 consultation when required.

11 (b) Supplies prosthesis when specially
12 indicated and not otherwise available.

13 (c) Assists in the maintenance of individuals
14 who are undergoing treatment on out-patient basis.

15 (d) Processes applications for training
16 of rehabilitation personnel, such as viso-therapists,
17 vocational counsellors, and occupational therapists.

18 (e) Assistance given to Nova Scotia Brace
19 and Appliance Center. Staff salaries are paid as
20 well as special equipment purchases.

21 (f) Assists the Nova Scotia Society for
22 the Care of Crippled Children by supporting the
23 travelling diagnostic clinic team.

24 (g) Close liaison is maintained with the
25 Vocational Educational Division of the Nova Scotia
26 Department of Education, which receives candidates
27 recommended for special training.

28

29

30



REHABILITATION PROJECTS

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consists of two doctors, a vocational counselor, a training specialist, an employment specialist, and the Co-ordinator. There is also provision for special consultation when required.

(b) Supplies prostheses when specially indicated and not otherwise available

who are undergoing treatment on out-patient basis
(c) Processes applications for training of rehabilitation personnel, such as vision-theorists, vocational counselors, and occupational therapists.
(e) Assistance given to Nova Scotia Vocational and Application Center. Staff salaries are paid as well as special equipment purchases.

(f) Assists the Nova Scotia Society for the Care of Orphaned Children by supporting the traveling diagnostic clinic team.

(g) Close liaison is maintained with the Vocational Rehabilitation Division of the Nova Scotia Department of Education, which receives candidates recommended for special training.



APPENDIX "V"

PROVINCIAL WELFARE PROGRAMS IN WHICH

THERE IS A MEDICAL COMPONENT

(Source: Department of
Public Welfare)

PART I

Programs in which there is a
medical requirement for eligibility

For many years going back to 1930 the Department paid Mothers' Allowances to certain needy mothers who were widowed and who had children under sixteen years of age. In 1942 this allowance was amended to provide for the payment of these allowances to women whose husbands were in provincial sanatoria or mental institutions. In 1943, this provision was broadened to include women whose husbands were permanently disabled to such an extent that they were unable to work. On August 15, 1961, 2341 allowances were in pay under this legislation and 903 of these allowances were being paid to wives of disabled husbands. The Department has an agreement with the Nova Scotia Medical Society in respect to this program and Blind Person's Allowance and the Society through its agent, Maritime Medical Care, provides medical benefits to the beneficiaries and dependents. Further reference will be made in this document to this arrangement.

The Mothers' Allowance Act was repealed at the 1960 Session of the Legislature and all of the provisions formerly contained in the Mothers' Allowance Act along with certain other broadening provisions were included in new Social Assistance legislation termed



(Source: Department of

Programs in which there is a
medical requirement for eligibility

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mothers who were widowed and who had children under
sixteen years of age. In 1948 this allowance was
amended to provide for the payment of these allowances
to women whose husbands were in provincial hospitals
or mental institutions. In 1948, this provision was
extended to include women whose husbands were permanently
disabled to such an extent that they were unable to
work. On August 15, 1951, 53% of these allowances were
under this legislation and 92% of these allowances were
being paid to wives of disabled husbands. The
Department has an agreement with the Nova Scotia
Medical Society in respect to this program and Blind
Persons' Allowance and the Society through its agent,
Maritime Medical Care, provides medical benefits to
will be made in this document to this arrangement.
The Mothers' Allowance Act was repealed at
the 1960 Session of the Legislature and all of the
Act along with certain other provisions were
included in new Social Assistance legislation to be



1 the Social Assistance Act. There is therefore no
2 Mothers' Allowance Act in Nova Scotia at the present
3 time and all former Mothers' Allowance payments are
4 being made now under the Social Assistance Act.

5 The Federal Government enacted the Disabled
6 Persons' Act in 1954, and the Province of Nova Scotia
7 enacted the necessary legislation and has paid allow-
8 ances to this category since January 1955 at the
9 maximum level permitted by the federal legislation.

10 Disabled Persons' Allowance is granted by the province
11 to persons who qualify under the conditions specified
12 in the Disabled Persons' Act and Regulations which is
13 Chapter 55 of the Acts of Canada of 1954. This Act
14 enables the Minister of National Health and Welfare
15 to make agreements with the provinces. The province
16 may pay allowances not exceeding \$55 per month and
17 collect fifty per cent of the costs from the federal
18 government. The federal government will share only
19 those payments made by a province where the recipient
20 is totally and permanently disabled as prescribed by the
21 Federal Regulations. The Regulations in respect to
22 disability are interpreted by a joint Medical Review
23 Board. It should be emphasized that there have been
24 changes in the definition of permanent and total dis-
25 ability as defined under this legislation in 1954 and
26 that there has been some broadening of the definition.

27 However, the definition has been such that
28 a considerable number of applicants have been excluded
29 on medical grounds under the Federal Regulations,
30 although for all practical purposes the rehabilitation

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that there has been some broadening of the definition.
However, the definition has been such that
a considerable number of applicants have been excluded
on medical grounds under the Federal Regulations,
although for all practical purposes the rehabilitation



1 of such persons cannot be effected so that the
2 individual might be able to support himself or his
3 family. In order to provide for these cases
4 ineligible under the Disabled Persons' Act and yet
5 very severely disabled and unable to support themselves,
6 the Social Assistance Act was amended and the following
7 provision made in it:

8 "From a date to be fixed by the Governor
9 in Council, Social Assistance may be granted
10 to a person who has attained the age of
11 eighteen years but who has not reached the
12 age of sixty-five who, by reason of permanent
13 disability, is unable to support himself
14 and who is not in receipt of an allowance
15 under the Blind Persons' Allowance Act or
16 the Disabled Persons' Allowance Act or Social
17 Assistance under Clause (a) or (b)."

18 These cases went into pay effective July 1st, 1960,
19 and at the moment there are 731 cases in pay under this
20 legislation.

21 The word "permanently" used under this section
22 is construed as meaning a disability which is con-
23 tinuous for an indefinite period of time or a
24 disability in which a definite prognosis cannot be
25 made and which, therefore will continue unabated for
26 a long period of time. Diseases such as tuber-
27 culosis, mental illness and gastric ulcer do not
28 qualify as permanent disabilities while under active
29 treatment or while the patient is considered treatable
30 with an expectation of whole or partial recovery



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family. In order to provide for these cases

ineligible under the Disabled Persons' Act and yet

very severely disabled and unable to support themselves

the Social Assistance Act was amended and the following

provision made in it:

"From a date to be fixed by the Governor

in Council, Social Assistance may be granted

to a person who has attained the age of

eighteen years but who has not reached the

age of sixty-five who, by reason of permanent

disability, is unable to support himself

and who is not in receipt of an allowance

under the Blind Persons' Allowance Act or

the Disabled Persons' Allowance Act or Social

Assistance under Clause (a) or (b)."

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culosis or permanent disabilities while under active

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with an expectation of whole or partial recovery



1 or rehabilitation. In general terms, a person
2 suffering from a treatable illness will not qualify
3 until maximum benefit has been obtained from the treat-
4 ment. A person in order to be eligible for Social
5 Assistance must have a disability so severe and his
6 residual work capacity must be so limited that he is
7 completely unable to earn a livelihood.

8 The only other provincial assistance program
9 under the Department of Public Welfare which involves
10 a medical component in determining eligibility is
11 Blind Persons' Allowance which is payable in much the
12 same manner as Disabled Persons' Allowance to needy
13 persons with a certain degree of blindness or visualiz-
14 cuity as defined by Federal Regulations.

15 To summarize, there are three provincial
16 public assistance programs with a specific medical
17 component namely, the degree of disability the appli-
18 cant must have in order to qualify. These programs
19 showed the following number of recipients for the
20 month of August 1961.

21	1. Blind Persons' Allowance-August 15, 1961	785
22	2. Disabled Persons' Allowance-August 15, 1961	2711
23	3. Social Assistance 7(a)-August 15, 1961	903
24		3600
25	Social Assistance 7(c)-August 15, 1961	710
26		recipients

27 Total - 8709 recipients and dependents
28
29
30

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suffering from a treatable illness will not qualify

until maximum benefit has been obtained from the treat-

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To summarize, there are three provincial

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component namely, the degree of disability the appli-

cant must have in order to qualify. These programs

showed the following number of recipients for the

month of August 1961.

1. Blind Persons' Allowance-August 15, 1961 795

recipients

2. Disabled Persons' Allowance-August 15, 1961 841

recipients
8600

Social Assistance (C)-August 15, 1961 710

recipients

Total - 8709 recipients and dependents



PART II

Provincial and Municipal
Public Assistance

We have just referred to those provincial public assistance programs in which the determination of eligibility is based on medical evidence. In addition to these there are a number of provincial social assistance programs and also old age assistance which are generally referred to as provincial public assistance. The total of all these is as follows:

Recipients of Blind Persons' Allowance 785
August 15, 1961

Recipients of Disabled Persons' Allowance 2711
August 15, 1961

Recipients of Provincial Social Assistance 12345
August 15, 1961

(This includes all types of Social Assistance and is the total of recipients and their dependents)

Recipients of Old Age Assistance 5400
August 15, 1961

Total 21,241 persons

In addition to these 21,241 recipients and dependents benefitting from Provincial Public Assistance there are approximately 11,137 persons benefitting from Municipal Assistance each month. Thus we have a total of 32,378 recipients and dependents who benefit from public assistance each month.

PART III

Medical Care programs for Public Assistance
Recipients and their Dependents

Reference has been made already to an agreement between the Province of Nova Scotia and the Medical Society of Nova Scotia. This agreement



Provincial and Municipal
Public Assistance

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public assistance programs in which the determination

of eligibility is based on medical evidence. In

addition to these there are a number of provincial

social assistance programs and also old age assistance

which are generally referred to as provincial public

assistance. The total of all these is as follows:

Recipients of Blind Persons' Allowance
August 15, 1961

August 15, 1961

Recipients of Provincial Social Assistance
August 15, 1961

(This includes all types of Social
Assistance and is the total of
recipients and their dependents)

Recipients of Old Age Assistance
August 15, 1961

Total 21,841 persons

In addition to these 21,841 recipients and

dependents benefiting from Provincial Public Assistance

there are approximately 21,137 persons benefiting

from Municipal Assistance each month. Thus we have

a total of 38,978 recipients and dependents who benefit

from public assistance each month.

Medical Care programs for Public Assistance
Recipients and their dependents

Reference has been made already to an agree-

ment between the Province of Nova Scotia and the

Medical Society of Nova Scotia. This agreement



1 entered into on March 1, 1950, now provides medical care
2 to certain social assistance recipients and their depen-
3 dents (old mothers' allowance cases and certain foster
4 child cases) and to recipients of blind persons'
5 allowance.

6 On August 15, 1961 there were 2341 social assis-
7 tance beneficiaries involving a total of 6640 dependents,
8 eligible for benefits under this plan and 785 recipients
9 of blind persons' allowance and 212 foster children
10 or a total in all of 9978 persons.

11 The Government of Nova Scotia pays the
12 Medical Society \$1.30 per month for each dependent and
13 the Society contracts with Maritime Medical Care as its
14 agent to administer the fund. The plan provides the
15 following benefits:

- 16 1. Home and office visits to the doctor.
- 17 2. Mileage charges are allowed when the doctor must
18 make a call more than two miles from his office.
- 19 3. Payment to a doctor up to twelve days care in
20 hospital for medical conditions.
- 21 4. Tonsillectomies and fractures are complete covered.
- 22 5. All surgican fees other than tonsillectomies and
23 fractures up to a maximum of \$30.
- 24 6. Obstetrical fees at home or in hospital.

25 It does not include routine physical
26 examinations, written reports, consultations, dental
27 conditions, drugs or certain laboratory tests.

28 It is interesting to note that while 9978
29 dependents are covered by this arrangement, this
30 represents only a small portion of the total number



entered into on March 1, 1960, now provides medical care to certain social assistance recipients and their dependents (old mothers' allowance cases and certain foster child cases) and to residents of blind persons' homes.

On August 15, 1961 there were 2341 social assistance beneficiaries involving a total of 6640 dependents eligible for benefits under this plan and 782 recipients of blind persons' allowance and SIS foster children or a total in all of 9978 persons.

The Government of Nova Scotia pays the medical costs of its social assistance beneficiaries and their dependents. The plan provides the agent to administer the fund.

1. Home and office visits to the doctor.
2. Mileage charges are allowed when the doctor must make a call more than two miles from his office.
- Payment to a doctor up to twelve days care in

Tonsilllectomies and tracheotomies are completely covered. All surgical fees other than tonsilllectomies and tracheotomies up to a maximum of \$200.

Obstetrical fees at home or in hospital. It does not include routine prenatal

conditions, drugs or certain laboratory tests. It is interesting to note that while 9978 dependents are covered by this arrangement, this represents only a small portion of the total number



1 of public assistance recipients and their dependents
2 who require a service of this type. Referring back to
3 the previous total in Part II, we have 32,378 persons
4 in receipt of all types of public assistance so that
5 thirty per cent of this group is covered by free
6 medical care.

7 PART IV

8 Who is Medically Indigent?

9
10 Are all of these recipients of public assis-
11 tance medically destitute or indigent or needy? By
12 inference we have assumed that recipients of Blind
13 Persons' Allowance and Mothers' Allowance are needy.
14 What of the others? In any discussion of medical
15 indigency, the question must be answered, when is a
16 person "indigent"? Does "indigent" mean the same as
17 "destitute"? What does "destitute" mean? Webster's
18 Dictionary states that "destitute" means, bereft of
19 resources, in want and misery, without the means of
20 bare subsistence or in absolute want. Certainly
21 "destitution" by this definition or by any other
22 reasonable definition would be a condition in which the
23 individual has no resources except perhaps his clothes
24 and a few sticks of furniture. It is doubtful if a
25 person owning a home could be considered "destitute",
26 although if he owned a shack and little else, he might
27 qualify as being "destitute" according to the defini-
28 tion. The words "needy" and "indigent" are used
29 interchangeably. The dictionary states that "needy"
30 means poor, or necessitous. It refers to a person
who is characterized by poverty. The word "poor" has



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Are all of these recipients of public assis- Who is Medically Indigent?

PART II

thirty per cent of this group is covered by free in receipt of all types of public assistance so that

the previous total in Part II, we have 32,378 persons

Referring back to



1 many meanings. Undoubtedly the word
2 "destitute" has come to indicate a person who is
3 relatively in more need or necessitous circumstances
4 than a person who is described as "needy" or "indigent"
5 or "poor". Being "destitute" is a condition of extreme
6 poverty in which the individual has no resources left.
7 A "destitute" person is certainly "poor" and "needy";
8 however, a person with, let us say, \$2,000 per year
9 income might be considered "poor" in one set of cir-
10 cumstances, while in another he might be considered
11 reasonably affluent.

12 Enough has been said to indicate that we use
13 the words "needy", "poor", "destitute", etc., with very
14 little thought for their meaning and as a matter of
15 fact, such terms only have a definite meaning if they
16 are defined by law or statute. This question is im-
17 portant because the welfare administration might consider
18 a person eligible for Old Age Assistance, Blind Persons'
19 Allowance or Disabled Persons' Allowance but the family
20 physician might not consider the same person medically
21 needy or indigent.

22 These distinctions as to when a person in
23 receipt of public assistance is able to pay for his
24 medical care are largely a matter of subjective judgment,
25 often coloured by emotion. For example, in 1950, prior
26 to the advent of the Old Age Security program, the
27 department entered into an agreement with the Nova
28 Scotia Medical Society, under the terms of which the
29 Medical Society agreed - through its agent Maritime
30 Medical Care - to provide medical services to the

many meanings. Undoubtedly the word

"destitute" has come to indicate a person who is relatively in more need or necessitous circumstances than a person who is described as "needy" or "indigent" or "poor". Being "destitute" is a condition of extreme poverty in which the individual has no resources left. A "destitute" person is certainly "poor" and "needy"; however, a person with, for us say, \$2,000 per year income might be considered "poor" in one set of circumstances, while in another he might be considered

Enough has been said to indicate that we use the words "needy", "poor", "destitute", etc., with very little thought for their meaning and as a matter of fact, such terms only have a definite meaning if they are defined by law or statute. This question is important because the welfare administration might consider a person eligible for Old Age Assistance, Blind Persons' Allowance or Disabled Persons' Allowance but the family physician might not consider the same person medically needy or indigent.

These distinctions as to when a person is receipt of public assistance is able to pay for his medical care are largely a matter of subjective judgment often colored by emotion. For example, in 1950, prior to the advent of the Old Age Security program, the department entered into an agreement with the Nova Scotia Medical Society, under the terms of which the Medical Society agreed - through its agent Maritime Medical Care - to provide medical services to the



beneficiaries of Old Age Pensions, Blind Persons' Allowances, and Mothers' Allowances. This arrangement continued for two years and was dropped in 1952 in respect to Old Age Pensions. The Medical Society claimed that Old Age Pension beneficiaries were abusing the privilege of free medical care by making too many unnecessary demands for service upon the medical profession. A very considerable number of physicians who were critical of the program maintained that the old age pensioners, who were then in receipt of \$40.00 per month, were quite capable of paying the costs of their medical care, and these doctors argued strenuously that the plan was an unwarranted intrusion by Government into an area where the pensioner was quite capable of making his own arrangements with his doctor. At the same time no such arguments were put forward in respect to medical care for the blind and while the agreement in respect to old age pensioners was discontinued in 1952 without any thought of negotiations in respect to needy recipients of Old Age Security or recipients of the new means tested program of Old Age Assistance, the agreement was continued without argument for the recipients of Blind Persons' Allowance. In fact these benefits are still available and no doctor to our knowledge has questioned the desirability of this arrangement. Why? Obviously because there is a great deal more sympathy for the plight of the blind as compared with the aged, and yet viewed objectively the need of the blind person, who is in receipt of \$55 per month for medical care is



This arrangement

was continued for two years and was dropped in 1950

by the Department of Health and Human Services

and the program was discontinued

were sharing the privilege of free medical care by

making too many unnecessary demands for services upon

the medical profession. A very considerable number of

physicians who were critical of the program maintained

that the old age pensioners, who were then in receipt

of \$10.00 per month, were quite capable of paying the

costs of their medical care, and these doctors argued

strenuously that the plan was an unwarranted intrusion

by Government into an area where the pensioner was

quite capable of making his own arrangements with

his doctor. At the same time no such arguments were

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negotiations in respect to needy recipients of Old

Age Security or recipients of the now money tested pro-

gram of Old Age Assistance, the argument was continued

without argument for the recipients of Blind Pension

Allowance. In fact these benefits are still available

and no doctor to our knowledge has dared demand the

feasibility of such arrangements. Why? Obviously

because there is a great deal more sympathy for the

plight of the blind as compared with the aged, and

yet viewed objectively the need of the blind person

who is in receipt of \$55 per month for medical care is

no greater than that of the person between 65 and 70 receiving \$55 per month.

Speaking in general terms, it can be stated that the three federally shared programs of Disabled Persons' Allowance, Blind Persons' Allowance and Old Age Assistance are more generous in respect to the definition of need and the payment itself than, for example, the provincial programs of Social Assistance. In the same manner, Provincial Social Assistance programs are by and large more generous in the definition and interpretation of need than is the case in Municipal Social Assistance legislation. A person in receipt of Municipal Social Assistance would likely be considered by the average physician as medically indigent and, therefore, requiring free medical care. However, the same physician might not be so ready to consider the person in receipt of Old Age Assistance as being medically indigent.

We must, of course, be guided by the nutritional standards set by the Department of Public Health. Physicians may draw sweeping generalizations from cases in which the person pays the costs of his medical services but this proves little or nothing except that he may have denied himself adequate housing or food or some other basic necessity of life in order to satisfy the sting of his pride and pay his medical bills. In our view, it would be more accurate to say that all persons in receipt of Disabled Persons' Allowance, Old Age Assistance, Blind Persons' Allowance, Provincial Social Assistance and Municipal Social

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say that all persons in receipt of Disabled Persons'
Allowance, Old Age Assistance, Blind Persons' Allowance and Old



1 Assistance are medically needy persons and if they are
2 to have adequate medical care without being denied
3 adequate nutrition and housing, some way must be found
4 of providing free medical services over and above the
5 amount of assistance now being paid to these indivi-
6 duals.

7
8 PART V

9 Old Age Security

10 No reference has been made in this document
11 to the very large number of persons over 70 years of
12 age in receipt of Old Age Security benefits from the
13 Federal Government. This group cannot be ignored in
14 any discussion of the medical components in the field
15 of welfare. Certainly their medical care needs are
16 just as real and pressing as the medical care needs
17 of municipal assistance recipients.

18 Up to 1952 the Province paid Old Age Pensions
19 to all needy persons 70 years of age and over. On
20 January 1, 1952, the Federal Government began paying
21 Old Age Security without a means test to all persons
22 aged 70 and over. At the time of the change there
23 were 21,085 persons in Nova Scotia receiving Old Age
24 Pension. The total number of persons aged 70 and
25 over at that time was estimated to be 35,485. It is
26 estimated that there are now more than 42,000 persons
27 aged 70 and over in Nova Scotia. Using the 1952
28 ratio of old age pensioners to the total population in
29 the age group of 70 and over in 1952, one would expect
30 to find 25,000 persons qualifying in 1961 on the basis

adequate nutrition and housing, some way must be found

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PART V

Old Age Security

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to the very large number of persons over 70 years of age in receipt of Old Age Security benefits from the Federal Government. This group cannot be ignored in any discussion of the medical components in the field of welfare. Certainly their medical care needs are

of municipal assistance recipients.

Up to 1952 the Province paid Old Age Pensions

to all needy persons 70 years of age and over. On January 1, 1952, the Federal Government began paying Old Age Security without a means test to all persons aged 70 and over. At the time of the change there were 21,087 persons in Nova Scotia receiving Old Age Pensions. The total number of persons aged 70 and over at that time was estimated to be 35,485. It is estimated that there are now more than 42,000 persons

aged 70 and over in Nova Scotia. Using the 1952 ratio of old age pensioners to the total population in the age group of 70 and over in 1952, one would expect to find 25,000 persons qualifying in 1961 on the basis



1 of a similar means test. We may assume that all those
2 persons aged 70 and over who would qualify for assis-
3 tance on the basis of a means test comparable to the
4 means test existent in 1952, would qualify for medical
5 care on the same basis as Old Age Assistance recipients,
6 Social Assistance recipients or recipients of
7 Municipal Assistance. Actually this estimate of
8 25,000 errs on the side of being too small because
9 the current means test for Old Age Assistance is con-
10 siderably more generous than the 1952 means test for
11 Old Age Pension.

12 PART VI

13 Child Care

14 We have been discussing the medical component
15 in the field of public assistance. It is much more
16 difficult to accurately define and assess the medical
17 component in the child welfare programs. On March 31,
18 1961, there were 2289 children under the care of the
19 Director of Child Welfare and the Children's Aid
20 Societies. Referring back to our discussion of such
21 terms as needy, poor, destitute, it can be said that all
22 of these children are needy since they are being main-
23 tained by public funds, provincial and municipal.

24 In theory, the amount provided by statute,
25 namely \$8.96 per week is supposed to cover all of
26 the child's board, clothing and medical care. In
27 point of fact if one should use the yardstick already
28 referred to of minimum standards of health and
29 decency and assume that full payment is being made
30 to foster parents for services rendered, the amount

... means test. We may assume that all those
 ... means test comparable to the
 means test existent in 1952, would qualify for medical
 care on the same basis as Old Age Assistance recipients,
 Social Assistance recipients or recipients of
 Municipal Assistance. Actually this estimate of
 \$2,000 error on the side of being too small because
 the current means test for Old Age Assistance is con-
 siderably more generous than the 1952 means test for
 Old Age Pension.

PART VI

Child Care

We have been discussing the medical component
 in the field of public assistance. It is much more
 difficult to accurately define and assess the medical
 component in the child welfare programs. On March 31,
 1961, there were 2889 children under the care of the
 Director of Child Welfare and the Children's Aid
 Societies. Referring back to our discussion of such
 terms as needy, poor, destitute, it can be said that all
 of these children are needy since they are being main-
 tained by public funds, provincial and municipal.
 In theory, the amount provided by statute,
 namely \$3.92 per week is supposed to cover all of
 the child's board, clothing and medical care. In
 point of fact if one should use the yardstick already
 referred to of minimum standards of health and
 decency and assume that full payment is being made
 to foster parents for services rendered, the amount



1 of \$8.96 per week would scarcely cover food and
2 clothing with no payment for services rendered by the
3 foster parent and no provision for medical care. Cer-
4 tainly, it is safe to assume that all of these
5 children are in necessitous circumstances from a
6 medical point of view and require free medical care
7 at the expense of the province and/or municipal level
8 of government.

9 There are seven private child caring
10 institutions, two private training schools for
11 delinquent girls and one government operated training
12 school for boys, caring in all for a total of 409
13 children. Not more than 80 of this number would be
14 wards of Children's Aid Societies and therefore counted
15 elsewhere in this statement. Thus we have a total of
16 329 children who are being cared for in these institu-
17 tions who are not wards of any particular organiza-
18 tion and who are completely dependent for their
19 medical care upon the ability of the institution to
20 provide such service.

21 The Nova Scotia School for Boys cares for
22 125 children and it is correct to say that since the
23 medical services in this school are provided by govern-
24 ment they are up to a reasonably satisfactory standard.
25 One would certainly not visualize that any new scheme
26 or plan of medical care would greatly improve the
27 quality of medical services available to this school.

28 This leaves 204 children in child caring
29 institutions and training schools operated by volun-
30 tary boards. Here it cannot be said that the

of \$8.96 per week would scarcely cover food and clothing with no payment for services rendered by the foster parent and no provision for medical care. Certainly, it is safe to assume that all of these children are in necessitous circumstances from a medical point of view and require free medical care at the expense of the province and/or municipal level of government.

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1 medical care provided to the children is satis-
2 factory because in almost all cases the board of manage-
3 ment of these institutions has insufficient funds to pay
4 for adequate services.

5 For the most part the physicians serving a
6 child caring institution are paid a small retaining
7 fee which is inadequate to cover the cost of services
8 rendered and it is assumed in all cases that the home
9 physician will make a considerable donation of his
10 own time and services. This kind of arrangement does
11 not in the long run ensure a high standard of medical
12 care.

13 Reference has not been made to the Nova
14 Scotia Training School for retarded children in
15 Truro which is also administered by the Department
16 and in which there are 180 children. Here the
17 medical services are adequate having regard to the
18 needs of the children and it is difficult to
19 visualize any new service which would provide a
20 better quality of medical care than is now available
21 to these children.

22 PART VII

23 Municipal Homes

24 There are fifteen municipal homes in the
25 Province operated by the municipal level of government.
26 These institutions house approximately 575 patients who
27 are either aged, infirm, mentally retarded or chroni-
28 cally ill. Here the need for a good standard of
29 medical care is obvious and requires no elaboration.
30

factory because in almost all cases the board of management of these institutions has insufficient funds to pay for adequate services.

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Reference has not been made to the Nova Scotia Training School for retarded children in Truro which is also administered by the Department and in which there are 180 children. Here the medical services are adequate having regard to the needs of the children and it is difficult to visualize any new service which would provide a better quality of medical care than is now available to these children.

MAY 1951

Municipal Homes

There are fifteen municipal homes in the Province operated by the municipal level of government. These institutions house approximately 275 patients who are either aged, infirm, mentally retarded or chronically ill. Here the need for a good standard of medical care is obvious and requires no elaboration.



1 In respect to more than half of the institutions and
2 at least half of the total population, it cannot be
3 said that the medical services provided are satisfac-
4 tory or that they meet even a reasonable minimum
5 standard. Here again the problem is much the same
6 as in the case of voluntary children's institutions.
7 The home physician is paid a stipend which in many
8 cases is too low or at least it is insufficient to
9 justify him giving the time and energy which the job
10 requires. In some cases the physician has no real
11 interest in the problem for which he is responsible.

12 SUMMARY

13 1. The Department administers three programs,
14 Blind Persons' Allowance, Disabled Persons' Allowance
15 and certain categories of Social Assistance, in which
16 disability is a requirement for eligibility. 8709
17 recipients and dependents are involved in these pro-
18 grams.

19 2. A growing number of disabled persons are
20 qualifying for public assistance benefits through the
21 federally shared, provincially administered Disabled
22 Persons' Allowance, Blind Persons' Allowance and the
23 Provincial Social Assistance payments shared by the
24 Federal Government under the Unemployment Assistance
25 Act.

26 In addition to the 8709 persons benefitting
27 from these types of assistance, an undetermined number
28 of the 11,137 persons receiving Municipal Assistance
29 qualify for such assistance because of disability.

30 It should also be noted that the Workmen's Compensation



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1 Board are paying compensation to persons, some of whom
2 are unable to work and who are needy because of disa-
3 bility. Still others are in receipt of federal
4 benefits through the Department of Veterans Affairs.

5 3. The existing agreement with the Nova Scotia
6 Medical Society provides limited medical care to the
7 recipients of Blind Persons' Allowance and certain
8 recipients of Social Assistance (old Mothers' Allow-
9 ance cases). Only thirty per cent of the total number
10 of recipients of provincial and municipal public assis-
11 tance are so covered and if the needy recipients of
12 Old Age Security referred to in Parr 5 are counted, the
13 statistics show 57,378 persons in need of assistance or
14 receiving or benefitting from assistance with 9978
15 persons covered by the two plans. Ontario, Saskatche-
16 wan and British Columbia provide free medical care to all
17 these categories or groups. Thus the medical benefits
18 provided by the province to needy persons covers only
19 17 per cent of the total who might or should be
20 eligible for such benefits if Nova Scotia followed the
21 same pattern as some other provinces.

22 4. The medical care benefits available to the
23 9978 recipients of provincial public assistance and
24 their dependents is not full or complete medical care
25 coverage and while \$1.30 per month payment from the
26 province to the Nova Scotia Medical Society is suf-
27 ficient to cover the current costs of such a program
28 as is described in Part 3 of this document, it would
29 not be sufficient if the program of medical care should
30 be made complete in its coverage. Neither is it

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and British Columbia provide free medical care to all these categories or groups. Thus the medical benefits

provided by the province to needy persons covers only 17 per cent of the total who might or should be

eligible for such benefits if Nova Scotia followed the same pattern as some other provinces.

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as is described in Part 3 of this document, it would not be sufficient if the program of medical care should

be made complete in its coverage. Neither is it



1 correct to say that the current program adequately
2 provides for all the medical needs of those covered.

3 5. It would appear that the total number of
4 persons in receipt of all kinds of public assistance,
5 needy persons receiving Old Age Security, children
6 under care, children in child caring institutions and
7 adults in municipal homes, totals approximately 60,000
8 persons. We have no way of knowing how many persons
9 in addition to these 60,000 are borderline cases
10 in respect to medical indigency; that is to say, per-
11 sons not in receipt of public assistance and who, if
12 the means test were used as a yardstick, would not
13 be eligible for even the most generous type of
14 assistance provided by the Federal Government, for
15 example, Old Age Assistance. These persons, however,
16 may be medically indigent because they have just
17 enough income or financial resources to provide a bare
18 minimum of subsistence for food, clothing and
19 shelter with no surplus for medical care. We are
20 unable to say how many persons there are in this
21 group.

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APPENDIX J

HEALTH OF ANIMALS DIVISION

CANADA DEPARTMENT OF AGRICULTURE

Outline of services conducted by the Health of Animals Division, Canada Department of Agriculture in the Province of Nova Scotia.

Out Division is charged with the administration of the Animal Contagious Diseases Act and Regulations, the Meat Inspection Act and Regulations and the Humane Slaughter of Food Animals Act and the Humane Slaughter Regulations within the province. For purposes of administration the Division is divided into three sections:

1. Animal Contagious Diseases Section
2. Meat Inspection Section
3. Animal Pathology Section

Breaking this down for the Province of Nova Scotia, under the Animal Contagious Diseases Section the province is divided into four subdistricts, with corresponding headquarters at Sydney, Truro, Windsor and Middleton, together with a port of entry staff at Halifax and service to Yarmouth, Sydney and other ports from the respective subdistrict offices. These people deal with all the named diseases in the Animal Contagious Diseases Act, as for example, glanders, maladie du coit, anthrax, hog cholera, mange, vesicular exanthema of swine, sheep scab, rabies, pneumoencephalitis, fowl pest, fowl typhoid and such other contagious or infectious diseases as may

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pneumoencephalitis, fowl pest, fowl typhoid and
such other contagious or infectious diseases as may



1 be designated by the Minister for these purposes.

2 When such diseases are suspected and reported
3 to our veterinarians we immediately make a full scale
4 investigation and diagnosis, the latter supported by
5 our own regional laboratory of Animal Pathology on
6 the Mount Allison University campus, Sackville, New
7 Brunswick, or in the main laboratory at Hull, Quebec.
8 When a named disease has been diagnosed, procedures
9 are then entered into to contain and eradicate it,
10 compensation being paid to the owner where applicable.
11 Ports of entry are manned for the purpose of inspecting
12 livestock and livestock products from foreign countries
13 as well as materials relative to livestock and live-
14 stock products. The above have restricted entry
15 into Canada and the province and in cases of countries
16 where named diseases have been diagnosed, embargoes
17 are placed to prohibit entry and dissemination of
18 that disease in this country.

19 In conjunction with the Animal Contagious
20 Diseases Section, we have a policy to supervise
21 garbage from international transport, as for example,
22 ships and aircraft. This garbage is taken from the
23 aircraft and burned immediately at the Halifax Inter-
24 national Airport. In the matter of ships, the gar-
25 bage is contained on board and taken to sea. Again,
26 this is for the prevention of dissemination of
27 disease. In connection with the garbage policy,
28 there are a number of farmers or hog feeders who gather
29 garbage from other than their own premises to feed to
30 their swine. This practice is prohibited unless they

be designated by the Minister for these purposes.

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to our veterinarians we immediately make a full scale

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there are a number of farmers or hog feeders who rather

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their swine. This practice is prohibited unless they



1 have a permit or licence from this Department. Before
2 a licence is granted, their premises are inspected
3 and must meet the requirements as laid down by the
4 Regulations under the Animal Contagious Diseases Act.
5 The basic requirement is that the garbage is thoroughly
6 cooked prior to feeding and that there is no possi-
7 bility of poultry or other livestock being fed or
8 contaminated by uncooked garbage. This policy has
9 proved to be very effective in the control of disease
10 in swine and poultry and the dissemination of
11 trichinosis. The incidence of this disease in
12 humans is so low in comparison to the United States
13 that they are now, at least in many places,
14 instituting a similar control on the feeding of
15 garbage to hogs there.

16 As well as the above, we have definite
17 eradication plans operating in the province, namely
18 for tuberculosis under the Restricted Area Plan, which
19 is on a county basis and covers the complete province;
20 the Accredited Herd Plan for the eradication of
21 tuberculosis which covers many of the purebred,
22 registered bovine herds in the province. Under
23 Brucellosis Policy, there are Brucellosis Control
24 Areas, which are on a county basis and the province
25 is almost completely certified. Another plan for the
26 eradication of Brucellosis is the Listed Herd Plan which
27 has some similarity to the Accredited Herd Plan in
28 that it is mainly confined to purebred and registered
29 bovine herds. Usually these herds are also accredited
30 under the tuberculosis policy, the thinking being

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1 that from these herds will come the best breeding
2 stock to improve the industry in the province. There-
3 fore, they should be free of these two diseases.

4 There is also an eradication plan for Johne's Disease
5 but this is considerably limited, although there
6 are a few herds in Nova Scotia.

7 As well as the above plans, when reports
8 of suspected rabies are received, an investigation
9 is made and where necessary, specimens are forwarded
10 to the laboratory. Where positive cases are uncovered,
11 it is policy to immediately notify the medical health
12 officer in the area in case of human involvement.

13 Where tuberculosis has been uncovered in the
14 human and cattle are on the premises, tuberculin
15 tests are conducted of all the cattle. Similarly, if
16 a case of undulant fever has been uncovered, a blood
17 test of the herd is conducted. The above is in
18 addition to the plans which are in operation.

19 Under the Meat Inspection Section, there
20 are two abattoirs and two poultry slaughtering and
21 eviscerating plants under supervision in the province.
22 The food animals and poultry going through these
23 plants receive meticulous ante mortem and post mortem
24 examination as well as being supervised through pro-
25 cessing until the product leaves the establishment.

26 In order to receive this service from the
27 Division, a plant must have volume as well as construc-
28 tion and facilities which come within the tolerance of
29 the Meat Inspection Act and Regulations. All diseased
30 or contaminated, or otherwise unfit for human



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There is also an eradication plan for John's Disease
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tion and facilities which come within the tolerance of
the Meat Inspection Act and Regulations. All diseased



consumption portions of carcasses and carcasses
are condemned and placed in inedible rendering units
on the premises, where they are sterilized and rendered
into inedible by-products. The term "inedible" means
inedible for human consumption.

As well as the rigid examinations as men-
tioned above, specimens of finished product are chosen
at random and forwarded to the laboratories for various
analyses to safeguard the product for human consumption.
It would be very difficult, for example, for a
product customarily eaten without further cooking to
leave an inspected establishment and have any live
trichinae or be infested with taeniasis or other
parasitic cyst formations, the products being subjected
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infestations.

Source: Department of Agriculture (Canada)

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Source: Department of Agriculture (Canada)



1 THE CHAIRMAN: Thank you very much, Mr.

2 Donahoe. You indicated that because of some shortness of
3 time, that we might expect some deficiency in the submis-
4 sion. Frankly, I cannot see it at this stage. I think
5 you have provided the Commission with what is a veritable
6 textbook on the situation in the Province of Nova Scotia,
7 covering the various services, and in your remarks here
8 this morning, you omitted reference to eight or ten
9 subjects that are also covered in this volume.

10 Now, the procedure will be that this submis-
11 sion will be studied and assessed, not only by members of
12 the Commission, but by our Research Director and Research
13 Consultant, and by our Medical Consultant, Dr. Jobin, and
14 it may be that further information will be required, in
15 which event we will communicate with you in that regard.

16 At this moment, there is one reference on
17 page 43, where you make reference to the Part II of the
18 submission, and you say: "At a later date, Part II, dealing
19 with forecast to 1970 and making general and specific
20 recommendations, will be forwarded". Perhaps I might
21 suggest now that if you find it possible, would you extend
22 that figure to 1980, because certain other forecasts and
23 studies which the Commission is arranging for, are going
24 to be projected to 1980, and if you would find it possible
25 to bring the Nova Scotia recommendations forward to that
26 period, it would be of some help.

27 Some members of the Commission may have some
28 questions, Mr. Donahoe.

29 HON. MR. DONAHOE: I would be very happy,
30 Mr. Chairman.



THE CHAIRMAN: Thank you very much, Mr.

Donahoe. You indicated that because of some shortness of time, that we might expect some deficiency in the submission. Frankly, I cannot see it at this stage. I think you have provided the Commission with what is a veritable textbook on the situation in the Province of Nova Scotia, covering the various services, and in your remarks here this morning, you omitted reference to eight or ten subjects that are also covered in this volume.

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HON. MR. DONAHOE: I would be very happy.



1 COMMISSIONER BALTZAN: I would like to
2 reserve questions I wish to put, they are very interesting
3 ones and will probably come up a little later.

4 COMMISSIONER STRACHAN: Mr. Chairman, through
5 you, I would like to refer to page 49, paragraph 247. I
6 am not sure that this is the proper time to mention this,
7 but I have noted that in this presentation, as well as
8 that of the University, Dalhousie, and also of the Nova
9 Scotia Dental Association, they have made reference to the
10 army training scheme rather reducing, and the words used
11 here are: "--drained away graduates who, under other cir-
12 cumstances, might have stayed in Nova Scotia." It is
13 suggested that these graduates under the army training
14 scheme stay with that scheme. I would not be sure of the
15 number who may have returned to this Province, but I think
16 I am reliably informed that a great many of those students
17 who after having served their compulsory three or five
18 years, have returned to private practice, which in essence
19 would be similar to the subsidization given by the New-
20 foundland Government, where they expect those students to
21 return and render service under the Public Health Depart-
22 ment for an equal number of years to that which they have
23 been trained. I think you will find that a large number
24 of these students are returning to private practice after
25 they have completed their three or five years compulsory
26 service.

27 HON. MR. DONAHOE: Mr. Chairman, I think if
28 the doctor were to reserve his question until the dentists
29 come forward, they would be able to give him better
30 figures.

JOHN BARTON: I would like to

reserve questions I wish to put, they are very interesting ones and will probably come up a little later.

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who after having served their compulsory three or five years, have returned to private practice, which in essence

would be similar to the subsidization given by the Newfoundland Government, where they expect those students to

return and render service under the Public Health Department for an equal number of years to that which they have

been trained. I think you will find that a large number of these students are returning to private practice after

they have completed their three or five years compulsory service.

HON. MR. DONALD: Mr. Chairman, I think it



1 My own understanding is that relatively few
2 of the dentists who have gone into the military service
3 have returned to practice in this Province. It is diffi-
4 cult to say whether these young men would have gone into
5 dentistry without the inducements offered to them if they
6 accepted the requirement to provide some service to the
7 military, or armed services. One never knows whether that
8 is what made it possible for them to become dentists, or
9 whether they would have been dentists anyway and were led
10 down the garden path, so to speak, from private practice
11 into the Government service. We believe that it is neces-
12 sary to render dental services to the armed services per-
13 sonnel, but on this I am perhaps not able to answer correctly
14 as to how many of these, or what percentage of persons so
15 trained have returned to practice in Nova Scotia, and I
16 take no issue that a high percentage have returned to
17 private practice generally speaking, but I think the percen-
18 tage who have returned to Nova Scotia is low, and others
19 will speak on this.

20 COMMISSIONER FIRESTONE: Mr. Minister, I
21 would like to compliment you on the comprehensiveness of
22 this brief, and it is indicative of the way in which the
23 Government of Nova Scotia is approaching this particular
24 problem. It will be of particular help to our research
25 staff, as well as to the Commission. If I may ask a few
26 questions, Mr. Minister. They are more of the type to
27 enable us to understand some of the things that you present
28 in the brief, and perhaps indicate some of the questions
29 that we are looking for answers. We do not expect that
30 you will necessarily answer those questions now, but

My own understanding is that relatively few

7 military, or armed services. One never knows whether that

Q whether they would have been dentists anyway and were led

I will speak on this.



1 perhaps you will consider answering them in the supple-
2 mentary brief dealing with recommendations, and also propo-
3 sals.

4 I would like to come first to the question
5 of availability of training of physicians in the Province
6 of Nova Scotia, on page 8 of your brief, paragraph 25.
7 You say in paragraph 25, one, that Nova Scotia does not
8 have sufficient physicians. Can we take it, sir, that in
9 your supplementary brief you will tell us a little bit
10 more of how many physicians you are short, and what steps
11 could be taken to encourage the training of an increasing
12 number of physicians, and how this can be done, and how
13 you can persuade some of these younger men then to take up
14 practice in the Province of Nova Scotia?

15 HON. MR. DONAHOE: Mr. Chairman, two or three
16 years ago, if anybody had posed me with a question of this
17 type to answer, I would have repeated what I was told by
18 the medical people, that there was a definite lack of
19 attraction to the medical profession, that young people
20 are not going to it in sufficient numbers. The length
21 and expense of the training period discouraged people from
22 going into the medical profession. In short, that we were
23 not getting enough applicants, and there was not enough
24 material coming forward to be trained for the profession.

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and expense of the training period discouraged people from
going into the medical profession. In short, that we were
not getting enough applicants, and there was not enough
material coming forward to be trained for the profession.



1 More recently I am given to understand in this
2 area that problem has been changing in character, and that
3 today we are not quite so badly off for available student
4 material. I think we have more material available than
5 was previously the case, or, the tendency seems to have
6 reversed itself and that more young people are coming
7 forward and seeking the training. We, in this Province,
8 would require at the present time to reach just the
9 Canadian average, and you will be judging for yourselves
10 how adequate that is -- would require another 110 doctors
11 to be practising in the Province of Nova Scotia. The
12 figures I use are provided on the basis of those doctors
13 providing medical service to the community. There are
14 many others engaged in research and teaching and a number
15 of related fields that are not really serving the general
16 public by providing medical services. We think we would
17 require that number additional.

18 As for the way in which persons can be
19 induced, I don't know. I think the supply -- at least,
20 I have been told the supply is improving. I think it is
21 still a very difficult profession to enter, with long and
22 arduous training; it is costly and expensive. One only
23 begins to get returns financially when he is relatively
24 older than the men who embark in other professions. In
25 endeavouring to get a measure of distribution of medical
26 services, we have a very modest program of subsidizing
27 doctors to a limited extent who will undertake to practice
28 in rural areas. As long as a man practising in a rural
29 area, particularly in the initial stages of his under-
30 taking his practice, we make available in appropriate

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1 circumstances, where municipal authorities will certify
2 the need exists, that without our subsidy the services
3 would not be otherwise available, we do subsidize. This
4 is not a very extensive program. It has been more exten-
5 sive in the past, but perhaps the reason it is not more
6 extensive is because fewer persons have thought to avail
7 themselves of the program, rather than response on the
8 part of the authorities.

9 As to how you can do more to train doctors,
10 it would seem to me you have to have two things: you have
11 to have available people wishing to go into the profession,
12 and also the facilities. I believe the Dalhousie Medical
13 School now handles more people than it used to recently,
14 and there are plans for expansion with respect to it. Our
15 problem is that we have to be satisfied that of the addi-
16 tional production of medical personnel from the University
17 we are able to retain sufficient of them in the Province.
18 We train people here; it is the only medical centre in
19 Eastern Canada, and we train people for all of the Atlan-
20 tic regions. A number of our medical students -- and there
21 are those better qualified to speak on this than I -- but
22 a number come from outside points. We have them from
23 other Commonwealth countries, and other parts of Canada as
24 well. These persons are trained with our facilities but
25 are not available to improve the overall situation of
26 providing medical care to the people of Nova Scotia. Just
27 how this could be overcome I don't know, but I think there
28 is considerable merit in some program which assists a
29 young man financially in embarking upon a medical profes-
30 sion, and it seems if such assistance could be forthcoming

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1 that it is only right and proper there should be tied to
2 that the obligation of rendering service in the community
3 which has made his education possible, and that is a prin-
4 ciple on which Newfoundland operates, and it has a consi-
5 derable amount of merit.

6 Of course, one must bear in mind if you have
7 a small population your demand is relatively small and you
8 perhaps can afford to be more generous in individual cases;
9 but, the greater the demand the greater difficulty to be
10 as generous. It would cost the Province of Ontario very
11 much more to adopt a principle of the type that Newfoundland
12 has than it **costs** Newfoundland.

13 Sometimes these programs are forced upon you
14 by circumstances, and while the program is not without
15 merit, one cannot say it applies in this jurisdiction or,
16 if it did, it should be carried to the same extent. It
17 seems clear there would likely be -- although I am not
18 willing to put the whole burden on it -- there would likely
19 be an increase in those seeking medical education if the
20 financial difficulties of doing that were eased in some
21 way. I think there are people who desire to be doctors
22 but are turned away by that very difficulty that faces
23 them, and if a program could be devised which would relieve
24 them to some measure I think there would be enough coming
25 forward, and what we would require then would be an expan-
26 sion of our training facilities which is under way.

27 COMMISSIONER FIRESTONE: I take it from what
28 you have said that if the Province of Nova Scotia has some
29 proposal for financial assistance for a young man going
30 into the medical field, such proposals would be included

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25 forward, and what we would require then would be an expan-
26 sion of our training facilities which is under way.

COMMISSIONER RIBSTONE: I take it from what

27 you have said that if the Province of Nova Scotia has some
28 proposal for financial assistance for a young man going
29 into the medical field, such proposals would be included



1 in your supplementary brief?

2 HON. MR. DONAHOE: We certainly will deal
3 with this in a supplementary brief. Whether we have any
4 definite proposals to make at this point I don't know,
5 but we will certainly give our views as to the desirabi-
6 lity of such a program.

7 COMMISSIONER FIRESTONE: If I may turn to
8 paragraph 25(3) when you speak of insufficient number of
9 physicians that are interested in practice in Nova Scotia
10 are being graduated from Dalhousie and other medical
11 schools to meet present and future requirements, Dalhousie
12 University in its brief to the Commission made two main
13 points as to the difficulties they are facing. The first
14 one was that they have a very substantial capital expendi-
15 ture program ahead of them in order to train the number of
16 men that are required for the Province of Nova Scotia to
17 take up medical and dental training, and they are making
18 the point it is increasingly difficult for them to obtain
19 the same proportion of funds which they have obtained in
20 the past from private sources, and they emphasize in future
21 they may require increased funds from public sources. The
22 second point they make is that the uncertainty of obtaining
23 grants from Government sources -- covering all governments;
24 it covers the four provincial governments and the Federal
25 Government -- but the uncertainty of obtaining the grants
26 makes it difficult for them to plan their expansion programs
27 both of a capital nature and of an operating nature. It
28 may be difficult for you to comment at this point on either
29 of those points, but can we expect some comments from you
30 in the supplementary brief?

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HON. MR. DONAGHE: We certainly will deal

with this in a supplementary brief. Whether we have any

definite proposals to make at this point I don't know.

COMMISSIONER FIRESTONE: If I may turn to

paragraph 95(2) when you speak of insufficient number of

physicians that are interested in practice in Nova Scotia

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schools to meet present and future requirements, Dalhousie

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of those points, but can we expect some comments from you



1 HON. MR. DONAHOE: By all means you can
2 expect that, and it will be done.

3 COMMISSIONER FIRESTONE: Mr. Minister, you
4 were talking about nurses and the difficulty you have of
5 obtaining funds and financial means both from your own
6 resources and that of the Federal Government to build
7 nurses' residences. Has the Province of Nova Scotia made
8 use of the facilities under the National Housing Act which
9 provides for certain financial possibilities in the
10 business of the building of nurses' residences?

11 HON. MR. DONAHOE: No, doctor. I am not
12 even aware that it is known that there was any help
13 available in the field of this type of construction.

14 COMMISSIONER FIRESTONE: Would it be possible
15 for this matter to be looked into, and if there are possi-
16 bilities, to advise the Commission as to the possibilities?

17 HON. MR. DONAHOE: I would be very happy to
18 do that because we are not particular how we get Federal
19 money. If we can get Federal assistance through another
20 medium to achieve this object in this field we would be
21 very happy to get it that way because our problem at the
22 moment is simply that we thought the measure of Federal
23 assistance was likely to be inadequate to our need. If
24 we can get another pipeline into the same treasury by
25 another route we will investigate it.

26 COMMISSIONER FIRESTONE: And you will advise
27 us in your supplementary brief?

28 HON. MR. DONAHOE: Yes, sir.

29 COMMISSIONER FIRESTONE: If I may turn to
30 the question of drugs on page 45, paragraphs 222 and 224,

HON. MR. DONAHOE: By all means you can

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HON. MR. DONAHOE: Yes, sir.

COMMISSIONER FIRESTONE: If I may turn to

the question of drugs on page 45, paragraphs 222 and 224,



1 you speak of the drug situation being most confusing in
2 paragraph 222, and of many complaints being heard regarding
3 the high cost of drugs in 224. Is there available in the
4 Province of Nova Scotia what the Government pays for drugs
5 both for drugs it provides to indigents and the cost of
6 drugs or the price of drugs being paid by the hospitals and
7 the comparison of these prices which you pay, the prices
8 which other Provinces pay, and what people at the retail
9 level pay, and if that information is available, can it be
10 made available to the Commission?

11 HON. MR. DONAHOE: I think information of
12 that nature is available. Just how readily available, I
13 am not prepared to say. I feel sure we could at least
14 ascertain for you the sums of money which we spend on drugs
15 and the prices which we pay for drugs, and perhaps make
16 some comparisons. Certainly, I think very much of what
17 you asked would be available, and I would be happy to say
18 we would seek that information in detail and make it part
19 of our further submission.

20 COMMISSIONER FIRESTONE: Thank you very much,
21 Mr. Minister. If I may turn to your section on dental
22 care at page 46, you made a very interesting point to the
23 Commission: you said that your Department was providing
24 mobile dental clinics. This is a very constructive move
25 in providing dental services to areas that do not have
26 dentists, and it is very commendable. You also mentioned
27 the difficulty you had last summer in getting enough
28 dentists to man these mobile dental clinics. Has the
29 Province any views as to how you can remedy this shortage
30 and this difficulty? After all, the service you plan to

of the drug situation being most confusing in paragraph 222, and of many complaints being heard regarding the high cost of drugs in 224. Is there available in the Province of Nova Scotia what the Government pays for drugs both for drugs it provides to hospitals and the cost of drugs on the price of drugs being paid by the hospitals and the comparison of these prices which you pay, the prices which other Provinces pay, and what people at the retail level pay, and if that information is available, can it be made available to the Commission?

HON. MR. DONAHUE: I think information of that nature is available. Just how readily available, I am not prepared to say. I feel sure we could at least

some comparisons. Certainly, I think very much of what you asked would be available, and I would be happy to say we would seek that information in detail and make it part of our further submission.

COMMISSIONER FIRESTONE: Thank you very much, Mr. Minister. If I may turn to your section on dental care at page 46, you made a very interesting point to the Commission: you said that your Department was providing mobile dental clinics. This is a very constructive move in providing dental services to areas that do not have dentists, and it is very commendable. You also mentioned the difficulty you had last summer in getting enough dentists to man these mobile dental clinics. Has the Province any views as to how you can remedy this shortage and this difficulty? After all, the service you plan to



1 provide is a laudable and constructive one. How does one
2 cope with a problem like this? If this question is too
3 difficult to answer, now, I would be happy if an answer was
4 forthcoming in the supplementary brief.

5 HON. MR. DONAHOE: The answer will be. At
6 the moment we do not have any plan to remedy the situation
7 because this is so wrapped up with the general shortage of
8 dentists that unless we were to embark on a program of
9 subsidizing young persons specifically for Government
10 service, it is difficult to know how we would resolve it.
11 The situation has really only become strictly acute in
12 this past summer, because up to now, although we had
13 difficulty, we were always able to man the units, and we
14 are providing as many units as we think we can afford.

15 COMMISSIONER FIRESTONE: I take it we will
16 get some proposals from you how you are planning to deal
17 with this problem. It is a very constructive thing, and
18 perhaps other provinces could follow the lead, but if they
19 do we would like to know what has happened in Nova Scotia.

20 HON. MR. DONAHOE: We might make a proposal
21 as to how you should deal with it, sir.

22 COMMISSIONER FIRESTONE: We would be delighted
23 to have such views.

24 If I may turn to page 48, paragraph 241,
25 you speak of 22% of the population of Nova Scotia are
26 using fluoridated communal water. You also have said a
27 little earlier in this submission that you have embarked
28 on an educational program. I take it from what you are
29 saying that the Province of Nova Scotia is convinced, and
30 your Department in particular, of the advantages to the

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COMMISSIONER THIRSTON: I take it we will

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do we would like to know what has happened in Nova Scotia.
NOW, MR. DONOHUE: We might make a proposal

as to how you should deal with it, also.
COMMISSIONER THIRSTON: We would be delighted
to have such views.

If I may turn to page 45, paragraph 241.
You speak of 22% of the population of Nova Scotia are
using fluoridated communal water. You also have told a
little earlier in this submission that you have embarked
on an educational program. I take it from what you are
saying that the Province of Nova Scotia is convinced, and
your Department in particular, of the advantages to the



1 citizens of your Province that will derive from the use of
2 fluoridated water?

3 HON. MR. DONAHOE: That is correct. My
4 dental advisors, in the Department certainly are proponents
5 of fluoridation. They believe it does serve a very useful
6 purpose. I am sure they believe it is thoroughly safe and
7 wherever possible they would urge upon any community to
8 establish a system of fluoridated water.

9 COMMISSIONER FIRESTONE: Have you had any
10 results as yet of the benefits derived from this program?

11 HON. MR. DONAHOE: I don't know that there
12 have been any scientific research or analysis into the
13 question of how this program may have benefited people in
14 this area, but I think their conviction rests upon inqui-
15 ries and experiments that have been made elsewhere, and
16 they operate on the principle that fluoridation in Nova
17 Scotia will be beneficial to the same extent and degree
18 as it is in other places; and in other places there are
19 studies which would appear to bear out the fact it is
20 beneficial. In any event, we are certainly in favour of
21 it and have been urging it as a departmental policy, I may
22 say with not altogether full success: one or two places
23 where we have felt there was a possibility of providing
24 fluoridated water have not seen fit to go along with that.

25 COMMISSIONER STRACHAN: May I interject here:
26 evidence is readily available on this particular subject
27 from the Department of Health and Welfare on the pilot
28 study which was made in Brantford, Stratford and Sarnia
29 over the past 15 years or so, and that can be readily had.

30 COMMISSIONER FIRESTONE: Thank you. Mr.

HON. MR. DONAHOE: That is correct. My

dental advisors in the Department certainly are proponents

of fluoridation. But I am not sure if they are

entirely convinced of its benefits or not.

They are not sure, and I am not sure.

establish a system of fluoridated water.

COMMISSIONER FIRSTON: Have you had any

results as yet of the benefits derived from this program?

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have been any scientific research or analysis into the

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it and have been urging it as a departmental policy. I may

say with not altogether full success: one or two places

where we have felt there was a possibility of providing

fluoridated water have not seen fit to go along with that.

COMMISSIONER GURCHMAN: May I interject here:

What is the present status of the fluoridation program?

Is it still in the hands of the Department of Health?

Is it being handled by the Department of the Environment?

over the past 15 years or so, and that can be readily had.

COMMISSIONER GURCHMAN: Thank you.



1 Minister, may I turn now to page 50 where you have your
2 summary, and you are making the point that the training
3 facilities at the dental school at Dalhousie University
4 are not being utilized to capacity.

5 HON. MR. DONAHOE: That is a very recent
6 development, Doctor, because until recently within the
7 last two or three years again, I think, the facilities
8 were far from adequate, but there has been a recent expan-
9 sion, and perhaps the demand has not yet caught up with
10 the supply, so to speak, because I hope that is in the
11 future, but this is a statement that could not have been
12 made two or three years ago, because two or three years
13 ago the facilities were so limited that they were pretty
14 well utilized. Now they have been expanded, and at the
15 moment are not being fully utilized. I think, myself,
16 though, that is a situation which time will cure to an
17 extent.

18 COMMISSIONER FIRESTONE: I take it we can expect
19 some proposals on how to encourage young people to enter
20 the dental profession to deal with the shortage in Nova
21 Scotia. I think the answer to that is "yes".

22 HON. MR. DONAHOE: I think the answer is
23 "yes".

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Minister, may I turn now to page 20 where you have your

facilities at the dental school at Dalhousie University

are not being utilized to capacity.

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development, Doctor, because until recently within the

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COMMISSIONER FISHBONE: I take it we can expect

some proposals on how to encourage young people to enter

the dental profession to deal with the shortage in Nova

Scotia. I think the answer to that is "yes".

HON. MR. DONAHUE: I think the answer is



1 COMMISSIONER FIRESTONE: Thank you very much.

2 You also mentioned in the same paragraph under (f):

3 "Dental costs, while not excessively high, are still
4 beyond the reach of many of our citizens". Are you
5 planning to make some proposals on this point?

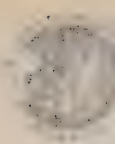
6 HON. MR. DONAHOE: I don't know that there
7 was any intention to make proposals on that point. We now
8 get into the general field of economics, and we in this
9 Province have a relatively low per capita income, and I
10 think it is obvious that there are sections of our popula-
11 tion who find it difficult to provide themselves with
12 dental and medical services. We had hoped that there
13 would come from your deliberations some recognition of
14 this problem, which is perhaps not common to us alone,
15 and there would be forthcoming proposals. Whether we
16 could give you any guidance as to what those proposals
17 will be I am not prepared to say at this time.

18 COMMISSIONER FIRESTONE: Thank you. I have
19 two more points. The first is with regard to item (h) of
20 the Terms of Reference of the Royal Commission which pro-
21 vides that the Commission look into the question of "The
22 methods of financing health care services as presently
23 sponsored by management, labour, professional associations,
24 insurance companies or in any other manner". Can we
25 expect from you some comment as to the adequacy of prepaid
26 medical care plans in the Province of Nova Scotia?

27 HON. MR. DONAHOE: Very definitely.

28 COMMISSIONER FIRESTONE: And there will be
29 exemptions and non-coverage, etc?

30 HON. MR. DONAHOE: Yes.



COMMISSIONER FIRESTONE: Thank you very much.

"Dental costs, while not excessively high, are still

beyond the reach of many of our citizens". Are you

planning to make some proposals on this point?

HON. MR. DONAHOE: I don't know that there

was any intention to make proposals on that point. We now

get into the general field of economics, and we in this

Province have a relatively low per capita income, and I

think it is obvious that there are sections of our popula-

tion who find it difficult to provide themselves with

dental and medical services. We had hoped that there

would come from your deliberations some recognition of

this problem, which is perhaps not common to us alone,

and there would be forthcoming proposals. Whether we

could give you any guidance as to what those proposals

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HON. MR. DONAHOE: Very definitely.

COMMISSIONER FIRESTONE: And there will be

exemptions and non-coverage, etc?



1 COMMISSIONER FIRESTONE: Thank you very much.

2 My last point was in paragraph 13 in which you emphasize
3 the question of priorities. This is a rather important
4 point. It is in line with item (k) in our own Terms of
5 Reference which provides that the Commission should look
6 into "The feasibility and desirability of priorities in
7 the development of health care services". If I understood
8 you correctly, Mr. Minister, you suggested that the Commis-
9 sion look into the question and come up with some recommen-
10 dations. I think this is a reasonable request and it is
11 in line with our instructions. Can we expect to get some
12 recommendation from the Government of Nova Scotia on the
13 subject of priorities?

14 HON. MR. DONAHOE: We certainly have given
15 great thought to this matter, and I think it is reasonable
16 for you to ask whether you will get that, and I think it
17 is reasonable for me to say that you will, because without
18 necessarily saying how these problems should be solved,
19 we will certainly rate them in the order of what we think
20 is the order of their importance.

21 COMMISSIONER BALTZAN: I do want to add my
22 compliments to you, sir, for the manner in which this
23 brief has been presented and the generosity on the part of
24 the Government. It is a comprehensive point of view in
25 relation to the whole problem, but I think it is so perfect
26 that I have not a single question to ask. The only thing
27 I want to say is that I would like to ask for a little
28 explanation on one point only. Mr. Minister, we have gone
29 a long way from the long time ago when the Department of
30 Public Health confined themselves to a particular field of

Public Health confined themselves to a particular field of a long way from the long time ago when the Department of

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1 endeavour in a collective manner for a collective purpose.
2 I remember the days of sanitation and immunisation. I
3 think it is extremely well put here. Perhaps you can
4 clarify it a little, number 9 in your introductory remarks
5 in the Summary, at the bottom of the page, "That a careful
6 study should be made as to the relative position of pro-
7 grams and practices carried out by the practitioner, the
8 Department of Public Health and the voluntary agency, from
9 the point of view of each assuming its own proper responsi-
10 bilities". There has been a considerable amount of merging,
11 and sometimes there is a certain amount of usurping. I am
12 glad to see you have the thing divided into three parts.
13 You deal with the question of the practitioner, you
14 certainly deal with the question of the Department of
15 Government. Then you take into consideration the importance
16 of contribution on the part of the voluntary agencies.
17 Now, would you at this moment perhaps be prepared to
18 explain the differences, perhaps such as you have in mind,
19 the integration or the separation? That is the part I
20 would like to have a little explanation on.

21 HON. MR. DONAHOE: Mr. Chairman, that is a
22 very excellent question and a very proper one, but also
23 an exceedingly difficult one with which to deal, and perhaps
24 the best way to answer it is by saying what I conceive to
25 be the function of the Department of Health, and if you
26 carve that out from the overall function of providing
27 health services, then what is left belongs to somebody
28 else. I am not prepared to say at what point, but we
29 conceive the function of the Department of Health to be in
30 the preventive field. We do not believe that the



1 the preventive field. We do not believe that the
2 conceive the function of the Department of Health to be in
3 else. I am not prepared to say at what point, but we
4 have been very much interested in this subject in connection
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1 Department of Health should get into the field of admini-
2 sterling health services to the individual. We have always
3 attempted to work through the profession. You have heard
4 what I said about the drug program, it is done through the
5 medical profession, making them available to the medical
6 profession on the condition that they are administered
7 under certain conditions. Fundamentally I think that is
8 the role of the Department of Health, that it is on a
9 broad preventive basis and anything prophylactic and pre-
10 ventive should be the pre-occupation of the Department of
11 Health.

12 I am sure the questioner will be the first
13 to agree that it is a difficult subject. You may see a
14 deficiency and attempt to correct it and in doing so you
15 may step away from your principle, but fundamentally I
16 believe that the Department of Public Health should
17 concern itself with those broad policies of protection and
18 the prevention of disease and as far as it is humanly
19 possible refrain from getting mixed up with the provision
20 of actual services. However, when it comes to the question
21 of providing even medical services in hospitals, then our
22 public health officers are obviously interested in knowing
23 what is done to eliminate the danger of epidemics and
24 infections, and so on, and then it may become mixed up
25 with the actual care of the public. But fundamentally
26 they do that from the point of view of prevention, and
27 that is my contention of the function of the Department
28 of Health. This gives you an idea of the lines along
29 which we think when we give you an appraisal of the
30 responsibility of each group, and I conceive the function

steering health services to the individual. We have always attempted to work through the profession. You have heard what I said about the drug program, it is done through the medical profession, making them available to the medical profession on the condition that they are administered under certain conditions. Fundamentally I think that is the role of the Department of Health, that it is on a broad preventive basis and anything prophylactic and preventive should be the pre-occupation of the Department of Health.

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1 of the Department of Public Health to be along the lines
2 that I have outlined.

3 COMMISSIONER BALTZAN: Thank you, sir. That
4 is an excellent explanation.

5 THE CHAIRMAN: Thank you, Mr. Donahoe and
6 Premier Stanfield.

7 MR. HALL: Mr. Chairman, may I suggest that
8 the Part I of the brief filed by the Government of Nova
9 Scotia be filed as an exhibit.

10 THE CHAIRMAN: Yes.

11
12 --- EXHIBIT NO. 2: Brief of the Government of Nova Scotia
13

14 THE CHAIRMAN: We now have the submission
15 from the offices of the Mayor of the City of Halifax.
16

17 SUBMISSION OF THE CORPORATION OF THE
18 CITY OF HALIFAX

19 Appearances: John E. Lloyd, Mayor
20 Allan R. Morton, Commissioner
21 of Health and Welfare

22 MR. LLOYD: Mr. Chairman, gentlemen of the
23 Commission, the Corporation of the City of Halifax is
24 certainly most pleased to co-operate with you in the studies
25 which you have undertaken, and the City Council has
26 directed its Commissioner of Health and Welfare, Dr. Morton,
27 who is with me, to present two submissions. The first
28 submission is presented herewith, and the second will be
29 presented at a subsequent hearing which is understood will
30 be heard in Ottawa early in 1962.

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CITY OF HALIFAX

SUBMISSION OF THE CORPORATION OF THE

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MR. HALL: Mr. Chairman, may I suggest that

Premier Stanfield.

THE CHAIRMAN: Thank you, Mr. Donahoe and



1 extensive homework in relation to the study of the fiscal
2 relations that exist overall between a city and the
3 Province. It may very well be that by early 1962 we will
4 be in a better position to have a more comprehensive
5 submission in relation to the fiscal relationship between
6 cities and provinces, and I think we may be able to make
7 some substantial contribution to the role that the munici-
8 pal government ought to play, and I mention that, because
9 it is not in the brief, because it is quite apparent that
10 cities must now devote themselves to the major problems of
11 the removal of blights, sometimes simply called slum
12 clearance. It may very well be that the role of the city
13 municipality is to devote its resources to their elimina-
14 tion, and this, of course, requires some appreciation and
15 re-appraisal of the division of responsibilities between
16 cities and the provincial authorities and the avenues open
17 to them to carry out their programs.

18 I may say that in addition to the presenta-
19 tion of this submission Dr. Morton and his staff are
20 available to render any assistance the Commission may
21 desire during its sessions in Halifax and also throughout
22 the period at any time of its inquiry.

23 On behalf of the City of Halifax I would
24 like to take this opportunity to express their pleasure
25 at the decision of the Government of Canada to undertake
26 this Commission and report on the health services and
27 financing thereof.

28 Finally, I would like to extend to you a
29 most cordial welcome to this historic city, the capital
30 of Nova Scotia.

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Finally, I would like to extend to you a most cordial welcome to this historic city, the capital of Nova Scotia.



1 DR. MORTON: Mr. Chairman, members of the
2 Royal Commission, I may say that this statement, Part I,
3 of the City's brief to you is quite brief, and the reason
4 is that I myself have been ill half of the present month
5 and also I have been moving my complete department and
6 offices, and for that reason I didn't have the time to
7 give my full attention to it since it was decided the City
8 should participate and present a brief to this Commission.
9 I felt, however, that there are certain problems and cer-
10 tain information which in this metropolitan area of Halifax
11 are somewhat unique and that possibly in order for you to
12 better understand the provincial brief and some of the
13 other briefs which will be presented to you, possibly a
14 somewhat brief presentation of the historical background,
15 the development of the Department of Health of the City of
16 Halifax should be before you.

17 The various elements which compose the
18 health services in the City are briefly surveyed, reviewed,
19 and, as the Mayor has stated, a far more detailed brief
20 will be submitted at a later date. The services which the
21 City Health Department do provide, of course, are far more
22 extensive in the City area, urban area, than those which
23 are supplied by the provincial Department of Health else-
24 where in this Province, and I believe, sir, that this is a
25 rule in most urban centres throughout this continent.

26 We have tried only to give you an understand-
27 ing, then, of the institutions and various departments
28 operated by the City and to point out some of the problems
29 which the City has faced in the development of its Health
30 Department.



DR. MORTON: Mr. Chairman, members of the

Royal Commission, I may say that this statement, Part I,

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should participate and present a brief to this Commission.

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tain information which in this metropolitan area of Halifax

are somewhat unique and that something in fact, and may be

rather different from what might be found in other parts of the

country which might be of interest to you, particularly

in view of the fact that the Commission is interested in the

various elements of the population of the City of Halifax.

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population of the City of Halifax are, of course, the

various elements of the population of the City of Halifax.

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which the City has faced in the development of its Health

Department.



I. As mentioned in the Provincial brief, our major difficulty has always been that of obtaining properly trained personnel. Our main competitors of course, are the Province and in some instances, divisions of the Federal Department of Health and Welfare and very frequently, difficulties in salary scales especially in the latter case complicates the recruitment of personnel for the City's Department.

II. In most instances, it is necessary to take on untrained personnel and then have them specially trained in that particular type of work. We have been assisted to some extent here by being able to obtain bursaries from the Federal Health Grants since 1948.

III. The division of costs between the City and the Province for some of these services has been a major problem which has been partially relieved by the coming into effect of the hospital care program.

IV. The major shortage of beds in this region, taking into consideration the plans for extension of present facilities, is that there is still no definite assurance of sufficient beds for convalescent and chronic patients, yet been considered or is it under study.

I may enlarge there by saying that in the survey carried out it was pointed out that 450 convalescent beds were required in this area. At the present time the City supplies 53 beds in a convalescent hospital, and there are some 20-odd beds for the convalescent type of patient, I believe, in the new extension of the Halifax Infirmary, not as yet opened.

We feel that the chronic invalid is the one

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1 who, at the present time - may be subjected to the greatest
2 problems because either they must be able to finance their
3 own care in a nursing home, which is expensive, or other-
4 wise become a welfare case.

5 Since the advent of the Hospital Insurance
6 Plan, it has been my Department's job to see that the
7 patients who do not qualify under the Hospital Insurance
8 are paid for, and we have great difficulty in doing this.
9 The definition of a hospitalized or convalescent patient
10 is not very good, in my opinion. When they cannot be
11 cared for at home, they become a welfare case and have to
12 be cared for in a welfare institution.

13 V. It is thought that because of the large
14 number of health services where improvement could be made,
15 that it would be almost impossible to recommend which one
16 should have priority.

17 We feel that we are in the same position as
18 the Minister of Health as regards to this, and I mention
19 here that we trust this Commission will assist us greatly
20 in deciding many of these problems for us.

21 We are very pleased to hear the Minister of
22 Health's answer to that. Certainly I have my own ideas,
23 and in the second part of my brief I shall put those for-
24 ward, but one, in doing that, must take into account the
25 local situation. It is much easier for somebody at a
26 distance to survey the picture and give the problem a
27 little bit of a push, and decide which one has priority,
28 than one working here directly with the group who has to
29 decide you are the one to get it and not anybody else.

30 Mr. Chairman, I said at the start that this

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decide you are the one to get it and not anybody else. Mr. Chairman, I said at the start that this



1 brief simply underlines the development of the whole situa-
2 tion. Possibly I might for a minute refer to page 2,
3 paragraph 4, the question of the service which the Welfare
4 Department does provide, and which, because of being an
5 urban centre and because help does not stop at the boundary
6 of a city, that when we are providing services not provided
7 elsewhere, we find that the suburbanites can and do take
8 advantage of it, and in my immunisation clinics, especially
9 in the last year or two, as regards polio vaccination and
10 so on, and in my T.B. program, my mass x-ray program, I
11 find that 30% of the individuals coming in are not citi-
12 zens of the City of Halifax, but come in from suburban
13 areas. I also feel that metropolitan health set-ups have
14 been organized in some of the larger cities in this Dominion,
15 and from meeting the Commissioners or Directors of those
16 right across Canada through the Canadian Public Health
17 Association, I find that some of these difficulties do
18 exist with them too, but in most instances, metropolitan
19 health set-ups are to more advantage than some of the
20 individual set-ups in closely allied communities.

21 I also want to point out to you that in the
22 services that we provide as a city, that these have changed
23 very materially within the last few years. Since the
24 coming into being of the hospital insurance program we have
25 closed our tuberculosis unit, which was previously our T.B.
26 hospital, because the number of T.B. cases requiring treat-
27 ment was brought down to a very small number, and we are
28 able to house that tuberculosis unit in what used to be the
29 infectious disease hospital, and closed out the infectious
30 disease hospital, and those patients, small in number, are

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infectious disease hospital, and closed out the infectious
disease hospital, and those patients, small in number, are



1 cared for in general hospitals. We are now using our
2 former T.B. hospital as a convalescent institution. This
3 gives us only 53 beds. We rent the second floor to the
4 Rehabilitation Council, because we feel that the facilities
5 should be supplied to them. Also, on the third floor we
6 rent to the Children's Hospitals in this area, because it
7 was better adapted and better for them to use as an infec-
8 tious unit for young children and infants, and that has
9 been working out fairly well.

10 The other problem in regard to institutions,
11 and one which the Mayor didn't mention, but which is
12 always coming up, is the fact that the City, up until this
13 time, never did operate a general hospital. I should not
14 say never did, because originally the Victoria General
15 Hospital, the main general hospital in the area, was
16 opened by the City, and this is a circumstance to which
17 the City didn't have too much control, because back at the
18 time of the organization of the City's Health Department,
19 in 1941, the City was told that if they went ahead with
20 the development of a modern Health Department and the
21 employment of public health nurses, and an addition to
22 their tuberculosis hospital, the Province would build a
23 new Victoria General Hospital.

24 I think, Mr. Chairman, that is all I have to
25 say at this time. As I stated, I would be only too glad,
26 on behalf of the Department, to give any other information,
27 or get any other information for you. I am sorry that our
28 brief at this time is so short, but more detail will be
29 forthcoming.

30 THE CHAIRMAN: Dr. Morton, this submission

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2 former T.B. hospital as a convalescent institution. This
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26 or get any other information for you. I am sorry that our
27 brief at this time is so short, but more detail will be

28 forthcoming.

29 THE CHAIRMAN: Dr. Morton, this submission



1 which we received will be Exhibit No. 3, and as with the
2 case of the Provincial submission, it will be studied by
3 our research people and by our consultants and certain
4 requests will be made for further information as they
5 may see fit to ask for, and we appreciate your offer of
6 co-operation and to give us any additional information
7 that you may be able to give.

8
9 --- EXHIBIT NO. 3: Part I of the Submission of the City
10 of Halifax.

11 Historical Information re the Development of the
12 Health Department of the City of Halifax

13 P A R T I

14 1. The outbreak of the Second World War
15 found Halifax without a modern, properly organized Health
16 Department able to meet with the health hazards accentuated
17 by the influx of large groups of the armed forces, as well
18 as numerous merchant marine from all of the seven seas, in
19 unprecedented numbers, calling at this port. The Health
20 Department was understaffed, and consisted only of a part
21 time Medical Officer of Health, with a full time secretary
22 to the Board of Health who was the Office Manager of the
23 Health Department and supervised three sanitary inspectors.
24 Alarming outbreaks of diphtheria, scarlet fever and cere-
25 brospinal meningitis along with an increase of other infec-
26 tious diseases added to the difficulties of overcrowding,
27 and this quiet peace time Nova Scotia capital was suddenly
28 transformed into a strategic military centre and naval
29 base; thus the health of Halifax was no longer of local
30

case of the Provincial submission, it will be studied by our research people and by our consultants and certain requests will be made for further information as they may see fit to ask for, and we appreciate your offer of co-operation and to give us any additional information that you may be able to give.

--- EXHIBIT NO. 3: Part I of the Submission of the City of Halifax.

Historical Information re the Development of the

Health Department of the City of Halifax

1. The outbreak of the Second World War found Halifax without a modern, properly organized Health Department able to meet with the health hazards accentuated by the influx of large groups of the armed forces, as well as numerous merchant marine from all of the seven seas, in unprecedented numbers, sailing at this port. The Health Department was understaffed, and consisted only of a part time Medical Officer of Health, with a full time secretary to the Board of Health who was the Office Manager of the Health Department and supervised three sanitary inspectors. Alarming outbreaks of diphtheria, scarlet fever and other infectious diseases added to the difficulties of overcrowding, and this quiet peace time Nova Scotia capital was suddenly transformed into a strategic military centre and naval base; thus the health of Halifax was no longer of local



1 importance only, but became of national and international
2 import.

3 2. The Federal Government, Provincial
4 Government and the City Government made an effort to
5 strengthen the Public Health services and in October, 1940
6 the first full time City Health Officer was appointed.

7 In 1941 on a recommendation of the Minister
8 of Public Health for the Province, Public Health Nurses
9 were employed and the Federal Government made a Grant to
10 assist the City in combating communicable diseases and
11 for use of its Health Department, to be spent on the
12 recommendation of the Deputy Minister of Health for the
13 Province. This Grant was to continue for the duration of
14 the War and one year thereafter.

15 3. Late in 1941 the City requested, through
16 the Minister of Public Health for the Province, that a
17 survey of the health services be carried out by the Inter-
18 national Health Division of the Rockefeller Foundation,
19 similar to the type of survey which they had previously
20 done for the Province of Nova Scotia. This survey was
21 carried out in 1942, and the report was adopted by City
22 Council early in 1943, and the Health Department was
23 expanded along their recommended lines. The Rockefeller
24 Foundation also financially assisted the City over a three-
25 year period in the implementation of their report. With
26 this reorganized, modern set-up functioning in the City
27 overcrowded by war-time conditions and overflowing into
28 the suburban areas, it was soon most apparent that the
29 health services being provided were being used by many of
30 the suburban people who worked in the City and whose

Government and the City Government made an effort to strengthen the Public Health services and in October, 1940 the first full time City Health Officer was appointed. In 1941 on a recommendation of the Minister of Public Health for the Province, Public Health Nurses were employed and the Federal Government made a grant to assist the City in combating communicable diseases and for use of its Health Department, to be spent on the recommendation of the Deputy Minister of Health for the Province. This grant was to continue for the duration of the War and one year thereafter.

3. Late in 1941 the City requested, through the Minister of Public Health for the Province, that a survey of the health services be carried out by the International Health Division of the Rockefeller Foundation, similar to the type of survey which they had previously done for the Province of Nova Scotia. This survey was carried out in 1942, and the report was submitted in 1943. The report was published in 1944, and the Foundation also financially assisted the City over a three year period in the implementation of their report. With this reorganized, modern set-up functioning in the City overcrowded by war-time conditions and overflowing into the suburban areas, it was soon most apparent that the



1 domicile was within a fairly short drive from their work.

2 4. Again, the City, along with the County
3 of Halifax and the Town of Dartmouth, requested through
4 the Minister of Public Health for the Province, that a
5 survey of the Public Health organization in the metropoli-
6 tan area be carried out by the Rockefeller Foundation;
7 again, this was done in 1945 and reported on in 1946 with
8 recommendations for development of a metropolitan health
9 set-up. Their recommendations were:

10 "It is recommended that the Public Health
11 jurisdictions of the City of Halifax, the
12 town of Dartmouth, and the Municipality
13 of Halifax be combined, and the health
14 services for the entire area be provided
15 for by the adoption of one or the other
16 of the following plans:

17 (1) that a joint board of health be created
18 by new legislation to serve as the local
19 health administrative unit, or,

20 (2) that the Provincial District Health
21 Unit for these areas be reorganized to
22 serve as the local health administrative
23 unit, in accordance with the provisions
24 of a voluntary agreement to be entered into
25 by the local governments in Halifax County
26 and the Provincial Department of Health".

27 This recommendation was considered by the
28 Minister of Health who had several conferences with the
29 Municipal Governments during 1948 and 1949; it is our
30 belief that had he (the Minister) lived another six months,

believe that had he (the Minister) lived another six months, Municipal Government during 1948 and 1949; it is our

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Jurisdiction of the City of Halifax, the

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survey of the Public Health organization in the metropolitan

the Minister of Public Health for the Province, that a

of Halifax and the Town of Dartmouth, requested through

4. Again, the City, along with the County



1 there would have been a metropolitan health department.
2 As it is now, the City operates a modern generalized
3 Public Health service costing the taxpayers of Halifax in
4 the vicinity of a quarter of a million dollars a year;
5 whereas the Public Health services of a preventive nature
6 everywhere else in this Province are provided for by the
7 Provincial Department of Health with very small contribu-
8 tions towards part time personnel only, by the Municipali-
9 ties concerned.

10 5. As the present Health Department of the
11 City had been organized and was functioning previous to
12 the Public Health Grants being implemented during 1948,
13 very little benefit accrued to the citizens of Halifax
14 from these Health Grants. The major benefit we have been
15 able to receive is the training at Federal Government
16 expense of personnel, and for the past four years a direct
17 Grant for assistance towards our Tuberculosis Control
18 Program.

19 6. The problems which were so apparent
20 during the early years of our Department have not decreased
21 even though there has been a considerable increase in the
22 Provincial services in the suburban areas. We still find
23 the clinics operated by the City Department of Health are
24 patronized quite extensively by suburban residents. Such
25 clinics as immunization, chest x-ray clinics, etc., show
26 that 30% of those in attendance come from outside the City
27 limits.

28 7. The City's program has become more
29 costly and more extensive covering more services for the
30 taxpayers and the personnel of the Department has also

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the vicinity of a quarter of a million dollars a year;

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7. The City's program has become more

costly and more extensive covering more services for the

taxpayers and the personnel of the Department has also



1 increased annually. Now we have twenty-one Public Health
2 Nurses, many additional clerks, a Nutritionist, a Mental
3 Health Clinic as well as other services not covered speci-
4 fically in the 1942 Rockefeller Foundation recommendations.
5 Cost of all of this has been borne directly by direct
6 taxation on the property owners.

7 8. At this point I do not think it is wise
8 to go into too much history of hospitals and hospitaliza-
9 tion in this area but I think it is essential that the
10 Royal Commission should realize that although the City, at
11 the present time, does not operate a general hospital
12 excepting the Halifax Convalescent Hospital, they have in
13 past years previous to the Hospital Insurance Commission's
14 free hospitalization plan, operated a Tuberculosis unit
15 (with financial assistance from the Province), an Infec-
16 tious Disease Hospital - the only one east of Montreal
17 open to receive patients from all over the Province until
18 its closure in January of 1959, a chronic Mental Hospital
19 for the care of mental patients for whom custodial care is
20 required for long periods of time, and have given substan-
21 tial annual Grants towards the Halifax Infirmary, a
22 general hospital - The Children's Hospital, again - the
23 only one east of Montreal catering to all the Maritime
24 Provinces and to the Salvation Army Grace Maternity Hospi-
25 tal. Many of these annual Grants were towards meeting the
26 deficit of these institutions as well as the Grant required
27 so that they could receive a per diem Grant from the
28 Province.

29 9. It is unique that in this area the muni-
30 cipality did not operate a general hospital. This has

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General hospital - The Children's Hospital, again - the
only one east of Montreal catering to all the Maritime
Provinces and for the entire New Brunswick Province
and for the entire Atlantic coast of Canada.
It is unique that in this area the munici-
pality did not operate a general hospital. This has



1 been somewhat changed within the last two years since the
2 coming into effect of the Hospital Insurance Act, and the
3 City has since that time operated a small Convalescent
4 Hospital in the building which used to be the City's
5 Tuberculosis Hospital.

6 10. The original Victoria General Hospital
7 was operated at one time by the City of Halifax and was
8 taken over by the Government over a hundred years ago. The
9 present Victoria General Hospital, which was opened in
10 1948, was completely built by the Provincial Government.
11 This was mentioned as part of an agreement between the
12 Minister of Public Health of the Province, who, in 1941,
13 wrote to the Mayor of the City of Halifax stating that if
14 the City increased its Health Department by the employment
15 of Public Health Nurses and enlarged its Tuberculosis
16 Hospital, the Government, in turn, would build a new
17 general hospital in Halifax. This was part of the basis
18 for the development of the present Health Department
19 operated by the City.

20 11. The City had operated an Infectious
21 Disease Hospital in the far north end of the City, which
22 building was destroyed in the 1917 Halifax explosion, and
23 following this, a temporary building was operated until
24 the permanent building was opened in 1928. This Infec-
25 tious Disease Hospital operated as such and admitted
26 patients from the whole area, including the Province,
27 until it was closed in January, 1959 and is now being used
28 as a tuberculosis diagnostic unit, and the headquarters of
29 the nursing division of the City Health Department and for
30 the Tuberculosis Control Program for the City. We have in

been somewhat changed within the last two years since the coming into effect of the Hospital Insurance Act, and the City has since that time operated a small Convalescent Hospital in the building which used to be the City's Tuberculosis Hospital.

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Disease Hospital in the far north end of the City, which building was destroyed in the 1917 Halifax explosion, and the permanent building was opened in 1928. This Infectious Disease Hospital operated as such and admitted patients from the whole area, including the Province, until it was closed in January, 1959 and is now being used as a general hospital. The City Health Department and the the Tuberculosis Control Program for the City. We have in



1 this institution twenty-two beds where cases suspected of
2 having tuberculosis are brought in for diagnosis, and if
3 requiring treatment are then transferred to one of the
4 Provincial institutions. Since the advent of free treat-
5 ment for tuberculosis in Nova Scotia in 1950, the Province
6 reimbursed the City on a per diem basis for patients in
7 the tuberculosis unit in the amount which had been their
8 per diem cost at the Nova Scotia Sanatorium in Kentville.

9 12. The Infectious Disease Hospital as
10 such, operated under the local hospital act for the
11 Province of Nova Scotia, but did not receive a per diem
12 Grant at any time from the Province. Under authority of
13 the Halifax City Charter the City could charge other muni-
14 cipalities at the local hospital ward rate of \$9.00 per
15 day, whereas our actual cost in maintaining a small hospi-
16 tal with a marked fluctuation in the number of patients,
17 at times went as high as \$15.00 per day.

18 13. The present building now used as the
19 Convalescent Hospital, formerly as a Tuberculosis Hospital
20 for the City, was originally opened in 1921 with a capacity
21 of fifty beds. This was increased to sixty-six beds
22 during the 1930's and in 1946 we opened a new wing with an
23 additional sixty-nine beds and with new kitchens and
24 dining-room facilities. The complete cost of this has been
25 borne by the City and we did admit to this unit, when we
26 had spare beds, patients from the immediate suburban areas.
27 Up until three years ago these patients received their
28 complete treatment here, including surgery when required,
29 but as the control measures gradually reduced the number of
30 patients requiring hospitalization, the building became

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3 requiring treatment are then transferred to one of the
4 Provincial institutions. Since the advent of free treat-
5 ment for tuberculosis in Nova Scotia in 1950, the Province
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26 had spare beds, patients from the immediate suburban areas.
27 Up until three years ago these patients received their
28 complete treatment here, including surgery when required,



1 only partly used and the second floor was turned over on a
2 temporary basis to the Nova Scotia Rehabilitation Council.
3 They have set up their out-patient department, two years
4 later followed by twenty beds for in-patients. At first
5 the City gave almost a complete service to these patients
6 with the exception of special services but for the last
7 one and one-half years the City has only supplied dieta-
8 tory services.

9 14. On the third floor of the new wing of
10 this building, due to overcrowding at The Children's
11 Hospital right next door, a connecting tunnel was built
12 and this third floor has become the Infectious Unit for
13 the Halifax Children's Hospital. This has greatly facili-
14 tated the work for the control of infection in small
15 children and the facilities they are using there are more
16 adaptable for the care of Infectious Diseases than their
17 previous infectious unit was.

18 15. This building, if completely available
19 for convalescent patients, could house 125 patients, it
20 would take a considerable load off the local general
21 hospitals; but until such time as our two tenants, the
22 Rehabilitation Council and The Children's Hospital, have
23 increased facilities in their own hospitals or new buildings,
24 the Convalescent Hospital can only accommodate fifty-three
25 patients.

26 16. The Halifax Mental Hospital is an old
27 building; again, situated in the same block as the Victoria
28 General Hospital, The Children's Hospital, the Convalescent
29 Hospital and close to the University Medical School. It
30 was built in the last century and is hard to modernize, and

only partly used and the second floor was turned over on a temporary basis to the Nova Scotia Rehabilitation Council. They have set up their out-patient department, two years later followed by twenty beds for in-patients. At first the City gave almost a complete service to these patients with the exception of special services but for the last one and one-half years the City has only supplied dietary services.

14. On the third floor of the new wing of this building, due to overcrowding at The Children's Hospital right next door, a connecting tunnel was built and this third floor has become the Infectious Unit for the Halifax Children's Hospital. This has greatly facilitated the work for the control of infection in small children and the facilities they are using there are more adaptable for the care of Infectious Diseases than their previous infectious unit was.

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16. The Halifax Mental Hospital is an old building; again, situated in the same block as the Victoria General Hospital, The Children's Hospital, the Convalescent Hospital and close to the University Medical School. It was built in the last century and is hard to modernize, and



1 has a total capacity for three hundred and thirty chronic
2 mental patients. A survey carried out by a special
3 committee appointed by City Council in 1950 recommended
4 that a new mental hospital for chronic patients be esta-
5 blished in the City which would have a bed capacity for
6 a minimum of 400 patients.

7 17. At that time the Provincial Government,
8 because of economic circumstances, had discontinued Grants
9 towards capital construction, but the City was still
10 willing to proceed if the Federal Grant was available.
11 The Writer took this up with the Federal Department but no
12 money was forthcoming until the Province was going to give
13 an equal amount. Therefore, the City, on its own, had
14 to renovate the local building to the best possible means
15 for the comfort and care of the patients and build a new
16 kitchen and dining room facilities at a cost of approxi-
17 mately one quarter of a million dollars. The Provincial
18 Government supplies free treatment for acute mental condi-
19 tions but once the acute stage is over, the patient is
20 diagnosed as a chronic case, they then become the responsi-
21 bility of the municipality in which the patient has
22 settlement. Within the last three years, however, the
23 Provincial Government at first paid one-third of the net
24 cost to the municipality and now this is one-half for the
25 operation of chronic mental hospitals which have met the
26 standards set down by the Provincial Government. The
27 City's institution has met that Standard.

28 18. The Mental Hospital was also a welfare
29 institution until February, 1959, when the City opened
30 Basinvlew Home in the north end of the City. This Home

has a total capacity for three hundred and thirty chronic mental patients. A survey carried out by a special committee appointed by City Council in 1950 recommended that a new mental hospital for chronic patients be established in the City which would have a bed capacity for

17. At that time the Provincial Government, because of economic circumstances, had discontinued grants towards capital construction, but the City was still willing to proceed if the Federal Grant was available.

The writer took this up with the Federal Department but no reply was received. The City, on its own, had an equal amount. Therefore, the City, on its own, had to renovate the local building to the best possible means for the comfort and care of the patients and build a new kitchen and dining room facilities at a cost of approximately one quarter of a million dollars. The Provincial Government supplies free treatment for acute mental conditions but once the acute stage is over, the patient is

diagnosed as a chronic case, they then become the responsibility of the municipality in which the patient has settlement. Within the last three years, however, the Provincial Government at first paid one-third of the net cost to the municipality and now this is one-half for the operation of chronic mental hospitals which have met the standards set down by the Provincial Government. The City's institution has met that standard.

18. The Mental Hospital was also a welfare institution until February, 1959, when the City opened a new Home in the north end of the City. This Home



1 was previously known as Rockhead Hospital operated by the
2 Federal Department of Health and Welfare as an isolation
3 hospital and on its grounds there is a small quarantine
4 hospital. During the War this building (Rockhead Hospital),
5 was used by the armed forces as an infectious disease unit
6 and also was used for the dependents of the armed forces
7 when they were coming back following the War. Large
8 numbers of Hungarian immigrants were housed here following
9 the Hungarian revolution when they arrived in Canada.

10 19. The Commission will note that in the
11 Provincial Brief and also we feel that one of the features
12 in the Health field not properly provided for in this area
13 is a hospital for the care of chronic cases. The patients
14 who no longer qualify under the Hospital Insurance Commis-
15 sion for treatment in a general hospital or even in the
16 Convalescent Hospital, if they cannot be cared for at home,
17 and require simple domiciliary care, must either go to a
18 private nursing home, which is most expensive, or become a
19 welfare case and be cared for at Basinview Home.

20 20. In a survey carried out by Dean C.B.
21 Stewart of the Medical School previous to the coming into
22 operation of the Hospital Insurance Commission, it was
23 recommended that there should be 450 convalescent and
24 chronic beds in the Halifax area. The definitions of
25 Convalescent and Chronic are debatable and the question of
26 how long the present free hospitalization will care for a
27 patient is becoming a problem which occurs frequently. He
28 also recommended additional beds for the care of acute
29 illness in general hospitals and with the new addition to
30 the Halifax Infirmary and the planned addition of the

was used by the armed forces as an infectious disease unit and also was used for the dependents of the armed forces when they were coming back following the War. Large numbers of infectious diseases cases were treated in the hospital during the War. The Commission will note that in the Provincial Brief and also we feel that one of the features in the Health field not properly provided for in this area is a hospital for the care of chronic cases. The patients who no longer qualify under the Hospital Insurance Commission for treatment in a general hospital or even in the Convalescent Hospital, if they cannot be cared for at home, and require simple domiciliary care, must either go to a private nursing home, which is most expensive, or become a welfare case and be cared for at Basinview Home.

20. In a survey carried out by Dean C.B. Stewart of the Medical School previous to the coming into operation of the Hospital Insurance Commission, it was recommended that there should be 450 convalescent and chronic beds in the Halifax area. The definitions of Convalescent and Chronic are debatable and the question of how long the present free hospitalization will care for a patient is becoming a problem which occurs frequently. He

the Halifax Infirmary and the planned addition of the



1 Victoria General Hospital, as well as the one under con-
2 struction at the Grace Maternity Hospital, the number of
3 beds for general purposes should meet the demand in this
4 particular region, but will not unless they are able to
5 find some accommodation for the convalescent and chronic
6 patients.

7 21. The Chairman of the Planning Commission
8 along with the Executive Director, met with the City in
9 1958 and at that time the Mayor, City Manager along with
10 the Medical Officer of Health, advised that whereas the
11 Town of Dartmouth and the County of Halifax provide no
12 hospitals whatsoever, a joint or co-operative movement
13 with the City could enlarge our present Convalescent Hospi-
14 tal on City owned property up to the required number.
15 However, ~~since~~ that time The Children's Hospital had a
16 survey carried out and are now requesting the City to sell
17 them the land on which this proposed extension was to be
18 placed. The Rehabilitation Council now housed in the
19 present Convalescent Hospital also have requested land
20 from the City of Halifax in the hospital area. These two
21 requests are being held in abeyance until a detailed plan
22 by inde~~pend~~ent appraisers can be secured, as to which
23 should be in the actual hospital zone and which should have
24 the highest priority.

25 22. Medical Care: The supply of physicians
26 in this area is fairly good. I understand from the Regis-
27 trar of the Provincial Medical Board that in the Halifax
28 region there are 426 qualified and registered physicians.
29 This includes, of course, the doctors in the armed services,
30 Federal and Provincial Health Departments and in the

Victoria General Hospital, as well as the one under con-
struction at the same hospital, the hospital
for general purposes, and the hospital for
particular region, but will not unless they are able to
find some accommodation for the hospital and the

21. The Chairman of the Planning Commission
stated that the hospital is now in the
process of being built, and that the hospital
the Medical Officer of Health, advised that whereas the
hospital is now in the process of being built, the
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between the City and the hospital, the hospital
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them the land on which this proposed extension was to be
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of the hospital can be secured, as to which

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trar of the Provincial Medical Board that in the Halifax
region there are 426 qualified and registered physicians.
Federal and Provincial Health Departments and in the



1 Medical School and the D.V.A. Hospital. The actual number
2 of active general practitioners in the City of Halifax is
3 fifty-two, and those that are specialized including the
4 pathological, radiological and bacteriological men is 126.
5 This does not include the salary personnel of the Provin-
6 cial Government or the University; so with 178 physicians
7 to care for a population of 91,000 there should be no
8 difficulty in obtaining medical care.

9 23. The welfare cases are looked after in
10 the Out-Patient Department in the Victoria General Hospi-
11 tal free of charge if ambulatory. The only medical care
12 for those confined at home is through the Halifax Visiting
13 Dispensary where they have three or four doctors who make
14 these calls for them and are paid a very low honorarium
15 for this particular work.

16 24. The Brief from the Nova Scotia Medical
17 Society will cover most of the recommendation and ideas
18 along the line of general practice and specialized care
19 in any Health Program and I do not intend, at this time,
20 to dwell on it.

21 25. Costs: The total Budget of the Halifax
22 City Health Department including the operation of the City
23 institutions has increased from a figure of \$170,450.00
24 in the 1939 Estimates of expenditures to \$1,198,507.93 in
25 1961. These figures do not include the Welfare expenses.

26 26. The Halifax area as elsewhere right
27 across the Country, there is a definite shortage of nursing
28 personnel both for staffing of institutions and for Public
29 Health purposes. In addition to this, other ancillary
30 personnel such as laboratory technicians, radiological

of active general practitioners in the City of Halifax is fifty-two, and those that are specialized including the This does not include the salary personnel of the Provincial Government or the University; so with 178 physicians to care for a population of 91,000 there should be no difficulty in obtaining medical care.

23. The welfare cases are looked after in the Out-Patient Department in the Victoria General Hospital free of charge if ambulatory. The only medical care for those confined at home is through the Halifax Visiting Dispensary where they have three or four doctors who make these calls for them and are paid a very low honorarium for this particular work.

24. The Brief from the Nova Scotia Medical Society will cover most of the recommendation and ideas along the line of general practice and specialized care in any Health Program and I do not intend, at this time, to dwell on it.

25. Costs: The total Budget of the Halifax City Health Department including the operation of the City Institutions has increased from a figure of \$170,450.00 in the 1939 Estimates of expenditures to \$1,198,507.93 in 1961. These figures do not include the Welfare expenses.

26. The Halifax area as elsewhere right across the country, there is a definite shortage of nursing personnel both for staffing of institutions and for Public Health purposes. In addition to this, other ancillary personnel such as laboratory technicians, radiological



1 technicians, etc., are also in short supply. Some means
2 of increased recruitment and training of these personnel
3 must be considered before further expansion of health
4 services can be carried out.

5 27. The care of the indigent in the area,
6 as far as preventive measures are concerned, is done in
7 the City's Health Department Immunization Clinics free,
8 but the indigents who require drug treatment must depend
9 on obtaining this through the Out-Patient Department at
10 the Victoria General Hospital, who in turn charge it to
11 the municipality; also they may receive drugs through the
12 Halifax Visiting Dispensary, a voluntary agency under the
13 United Appeal Fund.

14 28. Mental Health has been receiving consi-
15 derable prominence during the last few years. The City
16 operates a Mental Health Clinic for Children in conjunc-
17 tion with the Provincial Department of Health and the
18 Medical School. This clinic is under-staffed. We will
19 accept patients from all over the Province. The staff is
20 partially paid through Federal Health Grants and the
21 balance through the City Department of Health. We are,
22 however, dependent on the Out-Patient Department at the
23 Victoria General Hospital for adult mental consultation.

24 29. With the care of 330 chronic mental
25 patients, the administration of this Mental Health Clinic
26 and with the numerous requests from the Magistrate's Court
27 for Mental examinations for criminals and of individuals
28 with domestic problems, one of the urgent needs in this
29 Department is for a physician who is specialized in psy-
30 chiatry.

1 technicians, etc., are also in short supply. Some means
2 of increased recruitment and training of these personnel
3 must be considered before further expansion of health
4 services can be carried out.

5 27. The care of the indigent in the area,
6 as far as preventive measures are concerned, is done in
7 the form of a general health survey.
8 but the indigents who require drug treatment must depend
9 on obtaining this through the Out-Patient Department at
10 the Victoria General Hospital, and in some cases at
11 the municipality; also they may receive drugs through the

12 28. Mental Health has been receiving consi-
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26 with domestic problems, one of the urgent needs in this
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30. Dental Care: The City supplies three

part time dentists in our school health program, but with over 17,000 school children we are unable to do anything except emergency fillings or relief of pain. Extractions form most of the work carried out, but an educational program with the cleaning of the teeth as a prophylactic against dental caries is also carried out. We have had City fluoridation of our water supply for five years, and a survey is under way at the present time to compile the benefits which this program has provided to our school children.

31. Within the last year the City has had a full time Nutritionist, who, working with the Public Health Nurses, and in special clinics with prenatal and through the school teachers, is attempting to see that a better program of nutrition is brought about.

Physical fitness is not part of the City Health Department, but comes under physical education through the Board of School Commissioners.

A more complete picture will be composed as Part II of this Brief and will be delivered in Ottawa early in the new year.

Allan R. Morton, M.D., C.M., M.P.H.,
27th October, 1961. Commissioner of Health and Welfare

THE CHAIRMAN: We are grateful to you and to His Worship the Mayor.

Now, I understand you have a question, Dr. Firestone?

COMMISSIONER FIRESTONE: On page 12, in paragraph 30, you say that the City had a scheme of

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1 fluoridation of your water supply in operation for five
2 years, and that a survey is presently under way to compile
3 the benefits of this scheme.

4 DR. MORTON: It started this morning.

5 COMMISSIONER FIRESTONE: When do you expect
6 to complete the survey, and can you make the results
7 available to the Commission?

8 DR. MORTON: I hope the survey will be
9 completed before the end of this year, and the results
10 of that will be in the second part of my submission.

11 THE CHAIRMAN: Are there any other questions
12 from the Commission? Thank you very much.

13 Our next item on the agenda at this moment
14 is the submission on behalf of the Medical Faculty of
15 Dalhousie. It is coming on to 12. If you wish to open
16 the submission with the summary, we would be prepared to
17 proceed at this time. Who is going to make the presenta-
18 tion?

19 DR. KERR: Mr. Chairman, we would be very
20 happy to follow your wish in the matter. I understand
21 that you have an appointment to give an address at noon,
22 and I am sure it wouldn't be very satisfactory to you or
23 to us to rush our brief.

24 THE CHAIRMAN: 2 o'clock would suit you as
25 well?

26 DR. KERR: Thank you very much.

27 THE CHAIRMAN: The hearing will be adjourned
28 until 2 o'clock.

29

30 --- Luncheon adjournment

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THE CHAIRMAN: 2 o'clock would suit you as

DR. KERR: Thank you very much.

THE CHAIRMAN: The hearing will be adjourned



1 --- On resuming at 2 p.m.

2 THE CHAIRMAN: We are now ready to proceed
3 with the brief being presented by Dalhousie University.

4 SUBMISSION OF DALHOUSIE UNIVERSITY

5 Appearances: Dr. A.E. Kerr, President
6 Dr. C.B. Stewart, Dean of the
7 Faculty of Medicine
8 Dr. J.D. McLean, Dean of the
9 Faculty of Dentistry
10 Dr. H.D. Hicks, Vice-President
11 (on behalf of the Faculty of
12 Health Professions)

THE UNIVERSITY OF CHICAGO
OFFICE OF THE DEAN OF THE FACULTY
CHICAGO, ILLINOIS

Appointments: Dr. A.E. Kerr, President
Dr. C.B. Stewart, Dean of the
Faculty of Dentistry
Dr. H.D. Hoke, Vice-President
(on behalf of the Faculty of
Health Professions)



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College of Medicine
Bathurst

FACULTY OF HEALTH PROFESSIONS..... FINANCING OF THE FACULTIES OF MEDICINE AND DENTISTRY

Projections and Recommendations

Demand

Commission

History

Annual Cost

Finances

Present Situation

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Origin

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Academic Year

Course



SUMMARY AND RECOMMENDATIONS

1. Dalhousie University has the only Faculty of Medicine and the only Faculty of Dentistry in the four Atlantic Provinces and has recently established a Faculty of Health Professions, including at present the School of Nursing and College of Pharmacy and to include the School of Physiotherapy and Occupational Therapy and any other training programmes in fields relating to human health, as these are established. (G-1 to G-8) (All cross references are by paragraph number.)

2. The University has not been satisfied with just meeting the minimum requirements of accrediting agencies, but strives to maintain the highest quality of professional education and research.

Faculty of Medicine

3. The Faculty of Medicine is concerned not only with under-graduate medical education, but is the major medical research centre of the region. Medical scientists are educated in the pre-clinical departments in anatomy, microanatomy, bacteriology, biochemistry, physiology and pharmacology. Clinical specialists receive post-graduate training in the affiliated hospitals and Pathology Institute in medicine, surgery, obstetrics and gynaecology, paediatrics, psychiatry, pathology, diagnostic and therapeutic radiology, anaesthesia, urology and neurosurgery.

4. The Faculty operates the most extensive programme in Canada for the continuing medical education of general practitioners throughout the Atlantic Provinces.

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...diagnostic and therapeutic services, psychiatry, pediatrics, obstetrics and gynecology, radiology, anesthesiology, neurology and neurosurgery.

The Faculty operates the most extensive programme in Canada for the continuing medical education of



5. The Faculty provides all course in the medical sciences for dental students, and assists in the scientific and clinical training of other health personnel, including nurses, pharmacists, dental hygienists and medical technicians. (M-58, M-72)

6. More than 85 percent of English-speaking medical students from the four Atlantic Provinces study at Dalhousie. (Appendix D.)

7. Approximately 70 percent of the doctors entering practice in the four provinces are Dalhousie graduates. (Appendix E.)

8. The number of students from the Atlantic Provinces seeking admission to Medicine has increased during the past two years. There is no decline in the academic calibre of our medical students. (M-22, M-29-30)

9. The full-time staff of the pre-clinical sciences has increased in recent years from sixteen to thirty-one and of the clinical departments from two to twelve. The part-time staff has increased to 127. (M-9)

10. Several improvements have been made in the programmes of medical education at Dalhousie and tremendous growth has occurred in medical research in recent years. (M-50-51)

11. The University has been able to finance these improvements in medical education and the increase in staff by obtaining larger grants from the Governments of the four Atlantic Provinces and from various other sources. (F-15-17)

12. Because of the increase in students seeking admission to Medicine and the shortage of doctors in this

and clinical training of other health personnel, in-

cluding nurses, pharmacists,

technicians, and dentists.

More than 85 percent of English-speaking

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four Atlantic Provinces and from various other sources.



1 region, there is a need to expand the Medical School to
2 admit at least 75 and eventually 100 medical students per
3 year. This shortage will become much more acute as medical
4 insurance plans expand, whether voluntary or Government-
5 financed. Facilities should be provided also for at least
6 25 and, if necessary, 50 dental students in the medical
7 science departments. (M-25-27)

8 13. Present facilities are grossly inadequate,
9 except in the Departments of Pathology and Bacteriology.
10 In order to permit the expansion in enrolment and to pro-
11 vide much-needed research facilities, a new Medical Sciences
12 Building is required, which will cost approximately
13 \$4,500,000. Clinical research facilities must also be ex-
14 panded by remodelling the Dalhousie Public Health Clinic
15 at a cost of approximately \$250,000. (M-10, Appendix B.)

16 14. Most of the affiliated teaching hospitals
17 have recently enlarged or are planning to expand their
18 facilities. By 1965 teaching units in these hospitals will
19 be adequate for 75 students in the senior year. (M-10(e))

20 15. Unless there is a very large increase in
21 the number of students seeking admission to medicine from
22 the four Atlantic Provinces, the proposed enlargement of
23 the Medical School will be adequate for the immediate fu-
24 ture, but eventually another medical school may be required
25 in the region. (M-28)

26 16. Medical education is very expensive. The
27 average cost per medical student in 1961-1962 will be
28 \$ 3250. Provincial grants provide \$1080 (33.2%), federal
29 grants \$172 (5.3%) tuition fees \$564 (17.4%) and University
30 sources \$1434 (44.1%).

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1 17. Such an expensive educational programme
2 could not be operated at an adequate level by a privately
3 endowed institution without considerable assistance from
4 Governments. It is very doubtful whether the private sources
5 of the University can contribute to future increases at
6 the same rate as in the past seven years. Since 1954 Provincial
7 grants provided a total of \$688,677, University sources
8 provided \$721,666 and medical research grants amounted to
9 \$675,731. The Medical Alumni Fund provided \$140,000 for
10 the capital improvements in the Medical School Buildings
11 since 1954, and the Government of Nova Scotia constructed
12 the addition to the Pathology Institute. (F-11-18)

13 18. The system of provincial grants is not set
14 up on a stable basis and an annual appeal has to be made
15 to all four Governments. (M-6, F-3-8)

16 19. It is respectfully recommended to the Royal
17 Commission on Health Services:

18 (a) That the Government of Canada provide scholarships
19 and bursaries for medical students at a rate of \$2000 per
20 year, and that service requirements, if any, following graduation
21 should not interfere with the post-graduate training
22 of specialists. (M31-32, M-71)

23 (b) That the Government of Canada provide substantial
24 capital grants to aid in the expansion of both teaching
25 and research facilities in existing medical schools. The
26 immediate needs of Dalhousie are estimated at \$4,750,000.
27 (M-54-57)

28 (c) That annual grants be made to medical schools to
29 permit an increase in teaching staff in pre-clinical and
30 clinical departments and to pay higher salaries to full-time

in expensive educational programs

located at an adequate level by a relatively

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and research facilities in existing medical schools. The

immediate needs of Dalhousie are estimated at \$4,750,000.

(M-54-M-57)

(c) That annual grants be made to medical schools to

assist an increase in teaching staff in pre-clinical and

clinical departments and to pay higher salaries to full-time



1 staff and adequate honoraria to part-time clinical teachers.
2 These grants should be at least \$1000 per student now and
3 increased to \$2000 over a five-year period. (M-36, M-45-
4 49, M-71, M-77)

5 (d) That in any system of medical services insurance
6 there be specific safeguards to ensure development and main-
7 tenance of teaching units of adequate size (a) in the hos-
8 pitals affiliated with medical schools for undergraduate
9 teaching, and (b) in hospitals approved by the Royal College
10 of Physicians and Surgeons for post-graduate training in
11 specialties. (M-15-16)

12 (e) That any recommendation of the Commission relating
13 to medical education permit free choice of the University
14 as to whether or not it retains supervision over the year
15 of internship. (M-14)

16 (f) That plans for extension of health services be pre-
17 ceded by a realistic estimate of the personnel requirements,
18 especially the physician requirements, and that suitable
19 provision be made to ensure the necessary increase in phy-
20 sicians before any extensive increase in health services is
21 begun. This will require an interval of at least ten years.
22 (M-39-42)

23 (g) That Universities be asked to explore methods of
24 shortening the duration of medical education by lengthening
25 the academic term (M033-35)

26 (h) That methods be explored for improving the clinical
27 training of immigrant doctors before licensure in Canada.
28 (M-43-44)

29

30

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(M-43-44)



Faculty of Dentistry

20 The Faculty of Dentistry serves as the only center for dental education (para. D46), and the chief source of dental practitioners for the Atlantic region.

21 The present staff (para. D29 and D34) and physical facilities (para. D38) are excellent, although severely limited in number and size, even for the maximum number of students now possible in the school.

22 The Faculty has made dramatic improvements in staff, physical facilities, and teaching programmes within the past eight years (paras. D13, D24, D29, D38, D39, D74, D78, G7). Much improvement was made possible, initially, by generous financial support for annual operation from the W.K. Kellogg Foundation, and more recently by the greatly appreciated increase in the grants from provincial governments (Section F).

23 There is need, however, for much more generous financial assistance for the operation of the present Dental Faculty, and on a more stable basis. Present deficits must be eliminated (para. D74). More, qualified teacher--particularly on a full-time basis, are required now (para. D31), as well as for any future increase in the size of the school, as are technical staff who would contribute to an increase in the efficiency and effectiveness of the teaching programme (para. D36). Salaries of teachers should be improved immediately (paras. D32, D33, D34.).

24 There should be an immediate improvement in the facilities for the teaching of dental students in hospitals.

25 To stimulate the development of dental re-

general education (para. D46), and the chief
of dental practitioners for the Atlantic region.
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in staff, physical facilities, and teaching programmes.
Much improvement was made possible, in part,
by generous financial support for annual operation from
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Our financial assistance for the operation of the present
Dental Faculty, and on a more stable basis. Present con-
ditions must be eliminated (para. D44). More, qualified
teacher-particularly on a full-time basis, are required
now (para. D51), as well as for any future increase in the
size of the school, as are additional staff who would con-
tribute to an increase in the efficiency and effect of
the teaching programme (para. D56). Salaries of teachers
should be improved immediately (para. D43, D54).
There should be an immediate improvement in
the facilities for the teaching of dental students in hos-



1 search staff (paras. D23,D28) and teachers, it is recommend-
2 ed that money be provided to subsidize persons engaged in
3 advanced education programmes for these purposes.

4 26 An extension of short post-graduate and re-
5 fresher courses should be developed now, but graduate and
6 specialty education in dentistry is not possible at Dal-
7 housie until there has been an appreciable increase in the
8 size of the Faculty (para. D24).

9 27 At such time as the class size is sufficient-
10 ly large (forty to sixty students), basic medical science
11 departments, with adequate research facilities, should be
12 established as an integral part of the Dental Faculty (para.
13 D9).

14 28 There is an urgent need to increase the num-
15 ber of dental practitioners in the Atlantic region (paras.
16 D58-D71, incl.).

17 29 The Faculty of Dentistry at Dalhousie Univ-
18 ersity now admits all qualified students from the Atlantic
19 region who seek admission, and it could accommodate double
20 the number.

21 30 Even if the school was operating at capacity
22 with the present facilities, it could not provide, within
23 the space of twenty years, additional dentists for the At-
24 lantic region, in sufficient numbers to reach even the
25 present Canadian average population per dentist (para.D70).

26 31 Strong incentives are necessary to assure
27 the required number and quality of students (para. D97).

28 32 It is therefore recommended that these in-
29 centives include:

30 (1) Annual scholarships, each in the

An extension of short post-graduate and re-

search courses should be developed now, but graduate and

honors until there has been an appreciable increase in the

size of the Faculty (para. D44).

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the number.

with the present facilities, it could

the space of twenty years, additional

Atlantic region, in sufficient numbers to meet every

present Canadian average population per dentist (para. D70).

Strong incentives are necessary to attract

the required number and an list of associated (para. D77)

It is therefore recommended that new in-

centives include:

(1) Annual scholarships, each to the



1 amount of \$1,500 to \$2,000, for the four
2 years in the Faculty of Dentistry, to per-
3 mit the Dental Faculty to compete with other
4 areas of advanced education, for students
5 with high academic standing.

6 (2) A number of substantial bursaries
7 for needy students which would assist them
8 for at least the four-year period in the
9 Faculty of Dentistry. To be effective, the
10 amount should be about \$1,000 a year, which,
11 if added to summer earnings, would cover the
12 \$1,500 or \$2,000 per year which students es-
13 timate is their personal annual cost. Such
14 bursaries should be on a national basis,
15 preferably with 'no strings' other than an
16 undertaking to serve in Canada.

17 (3) Student subsidies similar to those
18 provided by the Royal Canadian Dental Corps,
19 sufficient to cover the cost of dental edu-
20 cation and living expenses, in return for
21 which the student would agree to some form
22 of public service for a specified number of
23 years.

24 33 The first two methods are to be preferred,
25 because they allow the graduate to have greater freedom in
26 the selection of a career, whether it be general or special-
27 ized practice, research, teaching, or public health.

28 34 Because of the shortage of dental personnel,
29 implementation of a full programme of state-financed dental
30 care seems impractical at this time. Any state dental health

amount of \$1,500 to \$2,000, for one year
year in the Faculty of Dentistry, to per-
mit the Dental Faculty to compete with other
areas of advanced education, for students
(2) A number of substantial purposes

for at least the four-year period in the
Faculty of Dentistry. To be effective, the
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1 care plan should be preceded by a programme which will pro-
2 vide greatly increased numbers of dentists.

3 35 Further, any solution to the manpower prob-
4 lem which results in a lowering of professional standards
5 of dental care, will compound the difficulties by discour-
6 aging recruitment to the professions, and a deterioration
7 in the dental schools.

8 36 It cannot be emphasized too strongly that
9 from the day a decision is reached to provide a new school,
10 a minimum of six years will elapse before the first student
11 graduates from it. This includes time for planning and
12 construction, recruitment of staff and a minimum of four
13 years required to educate a dental student.

14 37 In considering any extension of facilities
15 for dental education in the Atlantic Provinces, the follow-
16 ing points are pertinent (D105):

17 (1) The first step in a programme for the
18 expansion of dental education facilities in the Atlantic
19 region should be an increase in the size of the existing
20 school.

21 (2) Greater economy could be achieved with
22 a class of sixty students, but this figure should not be
23 exceeded.

24 (3) The size and location of the dental
25 school is determined, in part, by the necessity that it be
26 an integral part of the university, and by the size of the
27 community in which it is located. It is doubtful whether
28 an urban population appreciably less than 100,000 would pro-
29 vide the number of patients required for the variety of
30 teaching experience in the clinical programme.

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highly experienced in the clinical programme.



1 38 Part of the personnel problem can be solved
2 by the more extensive use of auxiliaries in practice. These
3 include the dental assistant, the dental hygienist, and the
4 dental technician. Training programmes for these groups
5 should be developed.

6 39 Since graduates of the dental school may
7 choose to practice in any area of Canada, it is recommended
8 that the Federal Government provide assistance to univer-
9 sities:

10 (1) For the annual operation of dental
11 schools in the amount of \$2,000 per student; and

12 (2) for the annual operation of schools of
13 dental hygiene in the amount of \$700 per student; and

14 (3) For capital construction at the rate of
15 \$20,000 per student.

16 40 It is reasonable to expect that auxiliaries
17 can be trained to do more of the technical procedures under
18 the direct responsibility of the dental practitioner, than
19 is now legally permissible. This possibility should be ex-
20 plored on an experimental basis, to determine the extent
21 to which additional duties can be assigned in an effective
22 and economically sound manner.

23 41 It is recommended that a system of Federal-
24 Provincial Public Health Grants be implemented, specifically
25 for dental health problems, similar to those available for
26 medicine. These should provide funds for clinical research
27 and other studies such as the project suggested in the
28 preceding paragraph; for specialized treatment centers such
29 as cleft palate clinics, diagnostic centers (particularly
30 in orthodontics and other specialty areas); and for the

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1 extension of dental public health services.

2 Faculty of Health Professions

3 42 School of Nursing: The Dalhousie School of
4 Nursing is at present providing a course leading to the
5 degree of Bachelor of Nursing as well as a diploma course
6 in:

- 7 (1) Nursing service administration;
8 (2) Public Health Nursing;
9 (3) Teaching in Schools of Nursing.

10 43 There would appear to be a need for eight
11 hundred additional nurses in Nova Scotia within the next
12 five or six years. The existing facilities for nursing
13 training can only meet a portion of this requirement. The
14 feasibility of establishing a central school of nursing in
15 Nova Scotia on an experimental basis ought to be investig-
16 ated. Financial support for nursing education at Dalhousie
17 ought to be reviewed and assurances given that adequate
18 support will be forthcoming on a permanent basis.

19 44 College of Pharmacy: The College of Phar-
20 macy, as a division of a Dalhousie Faculty, is only in its
21 first year of operation, and it is not yet easy to state
22 with certainty and in detail what the future requirements
23 will be.

24 45 Enrolment for the present year has increased
25 more than fifty percent over that of the previous year.
26 Most of this increase is accounted for by students under-
27 taking a four-year degree course which is being offered for
28 the first time in the Atlantic Provinces.

29 46 Cost of operation for the current year is
30 estimated to be approximately \$30,000, which is expected

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1 to be available from existing sources. It is anticipated
2 that this figure will approximate \$65,000 when the programme
3 is fully implemented and in order to accommodate one hun-
4 dred and ten students. Student fees and other foreseeable
5 sources of income may produce an additional \$10,000. The
6 remaining \$25,000 will have to be provided from other
7 sources.

8 47 Unless the Federal university grants are
9 substantially increased, we recommend that special grants
10 for the training of health personnel be provided by the
11 Federal Government.



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BRIEF

TO THE ROYAL COMMISSION ON HEALTH SERVICES

FROM

DALHOUSIE UNIVERSITY

HALIFAX, NOVA SCOTIA

October, 1961

Mr. Chairman and Members of the Royal
Commission on Health Services:

G-1 Introduction Dalhousie University is pleased to have the opportunity of presenting a brief to the Royal Commission on Health Services. Our staff has a natural interest in the health and welfare of these Atlantic Provinces. The University's activities in numerous fields are closely related to those of the community. However, our main responsibility, so far as it touches upon the interests of your Commission, lies in the field of medical and dental education and research, and the training of health personnel in other related professions and vocations. Dalhousie University has the only Faculties of Medicine and Dentistry, the only School of Nursing which gives training in Public Health Nursing, the only School of Pharmacy in the four Atlantic Provinces and other developments are also under consideration. It is natural that these professional faculties should have associated with them a number of other educational and research activities relating to health. In addition, programmes of education and research in the Departments of Political Science, Sociology, the Institute of Public Affairs, and several other departments touch upon various aspects of the health and welfare of the community.

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1 G-2 Founding of Dalhousie Dalhousie University

2 was founded in 1818 of the idea that a college should be
3 open to all, regardless of class or creed. In an age when
4 denominational preference still dominated higher education
5 in Nova Scotia, this was a novel concept, but on which
6 Lord Dalhousie was confident would produce a great instit-
7 ution in succeeding years. It was intended that Dalhousie
8 University would develop in imitation of the University of
9 Edinburgh as a centre of knowledge relating itself directly
10 to the affairs and needs of the developing community. Al-
11 though the primary function of the University has been to
12 produce educated young men and women who would be useful
13 servants of society, efforts have been made to enlarge
14 this public service in several respects, in spite of the
15 financial limitations of a private institution.

16 Establishment of Professional Faculties

17 G-3 The Faculty of Medicine was established in
18 1868, fifty years after the founding of the University it-
19 self. This was the fifth Canadian Medical School, having
20 been preceded by McGill, Queens, Toronto and Laval. It
21 was replaced for a time by the independent Halifax Medical
22 College, but since 1911 has been a Faculty of Dalhousie
23 University.

24 G-4 The Faculty of Dentistry originated as the
25 Maritime Dental College, established by the Nova Scotia
26 Dental Association in 1908. Shortly afterwards, arrange-
27 ments were made between the Association and the University
28 whereby the Maritime Dental College became the Faculty of
29 Dentistry, in time for the first class of graduates to
30 receive their degrees from Dalhousie University in 1912.



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1 This arrangement marked the foundation of the first Univ-
2 ersity Faculty of Dentistry in Canada, although not the
3 first dental school.

4 G-5 The Maritime College of Pharmacy was founded
5 in 1911, and given quarters in the University. Although it
6 was affiliated with Dalhousie University, the College oper-
7 ated under its independent Board of Governors, of which
8 the President of Dalhousie was Chairman. During the past
9 year, the Governors of the Maritime College of Pharmacy
10 requested incorporation of the College within the University,
11 and accordingly, in 1961, it became the College of Phar-
12 macy of Dalhousie University.

13 G-6 The University extended its role as an ed-
14 ucationation centre for other health personnel when, in
15 1948, a request was made to the Governments of the four
16 Atlantic Provinces for support in the establishment of
17 training programmes in public health nursing, Psychiatry
18 and clinical psychology. With assistance from grants by
19 each of the Governments, the training of public health
20 nurses, psychiatrists and clinical psychologists was begun.
21 The University has also recognised the shortage of training
22 facilities for physiotherapists and occupational therapists
23 in the four Atlantic Provinces, and the Board of Governors
24 has approved a recommendation from the Faculty of Medicine
25 that a School of Physiotherapy and Occupational Therapy
26 be established as soon as space and financial support can
27 be obtained.

28 G-7 In 1961 the University established a Fac-
29 ulty of the Health Professions to include the School of
30 Nursing, the Maritime College of Pharmacy, the School of



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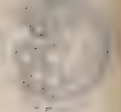
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1 Physiotherapy and Occupational Therapy when established and
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 5 Committee of the Faculty of Medicine is at present inves-
 6 tigating the feasibility and desirability of a University
 7 training programme for medical laboratory technicians. The
 8 Faculty of Dentistry has established this year a School for
 9 the training of dental hygienists.

10 G-8 Dalhousie University therefore feels justifi-
 11 ed in making the claim that it is the central unit for the
 12 education of health personnel in the four Atlantic Provin-
 13 ces, and that it has been making progress in meeting new
 14 needs as rapidly as existing facilities and very limited
 15 financial support will permit.

16 G-9 Recommendations will be made in each section
 17 where relevant. Most of the information and recommendations
 18 relate to the following sections of the Commission's terms
 19 of reference: (d) present and future requirements of
 20 health personnel, (e) methods of providing such personnel,
 21 with the best possible training and qualifications, (f)
 22 present physical facilities (with reference to educational
 23 facilities), (j) medical research and (k) priorities.

24 G-10 Information will be presented in separate
 25 sections on the Faculty of Medicine, the Faculty of Den-
 26 tistry and the Faculty of Health Professions. These sec-
 27 tions will be discussed by my colleagues, Dr. C.B. Stewart,
 28 Dean of Medicine, Dr. J.D. MacLean, Dean of Dentistry and
 29 Dr. Henry D. Hicks, Vice-President of Dalhousie and Dean
 30 pro tem of the Faculty of Health Professions.



Physiotherapy and Occupational Therapy when established as other training programmes in fields relating to human health which may later be approved by the Senate and Board of Governors for inclusion in the University programme. A Committee of the Faculty of Medicine is at present investigating the feasibility and desirability of a University training programme for medical laboratory technicians. The Faculty of Dentistry has established this year a School for the training of dental hygienists.

9-8 Dalhousie University therefore feels justified in making the claim that it is the central unit for the education of health personnel in the four Atlantic Provinces, and that it has been making progress in meeting new needs as rapidly as existing facilities and very limited financial support will permit.

9-9 Recommendations will be made in each section where relevant. Most of the information and recommendations relate to the following sections of the Commission's terms of reference: (d) present and future requirements of health personnel, (e) methods of providing such personnel with the best possible training and qualifications, (f) present physical facilities (with reference to educational facilities), (g) medical research, and (h) priorities.

9-10 Information will be presented in separate sections on the Faculty of Medicine, the Faculty of Dentistry and the Faculty of Health Professions. These sections will be presented in the following order: Dean of Medicine, Dr. J.D. Macleod, Dean of Dentistry and Dr. Henry D. Hicks, Vice-President of Dalhousie and Dean of the Faculty of Health Professions.

1 G-11 On behalf of Dalhousie University, may we
2 express sincere thanks to the Royal Commission on Health
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4 extend best wishes to you for success in your very impor-
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FACULTY OF MEDICINE

M-1 Founding of the Faculty After its founding by the University in 1868, the Faculty of Medicine soon encountered the problem which has not yet been solved almost a hundred years later, financial stringency. Difficulties soon arose in the financing of the small Medical School. An approach was made to the Provincial Government to obtain financial assistance. For some reason it seemed difficult for the Government to provide a grant to Dalhousie University, but they could provide aid to an independent body. In 1874, therefore, the Halifax Medical College was incorporated by an act of the Legislature, received a grant of \$800 per year and functioned as an independent School until 1885. It then became affiliated with Dalhousie University but was in fact a proprietary medical school operated by physicians of Halifax.

M-2 Flexner Survey Like several other medical schools in Canada, the Halifax Medical College received a rude jolt when the Carnegie Foundation for the Advancement of Teaching, published the famous Flexner Report in 1910. As a result, the Halifax Medical College went out of existence and the University re-assumed full responsibility for the Faculty of Medicine in 1911. During the next ten years, a few full-time staff members were appointed in some of the Medical Science Departments, but the clinical teaching was continued by the practitioners of Halifax.

M-3 Endowment, Buildings and Accreditation In a crucial effort to meet the standards for accreditation based on the Flexner Report, Dalhousie University sought and obtained support from the Rockefeller and Carnegie

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Founding of the University After its founding



1 Foundations in 1920. The University received on million
2 dollars for the Medical School, which made possible the
3 erection of the Medical Science Building and the Public
4 Health Clinic, and provided a certain amount for equipment
5 and the endowment of the medical science departments in
6 which both medical and dental students receive instruction.
7 These gifts from the Rockefeller and Carnegie Foundations
8 brought the Medical School through its first major crisis.
9 It received accreditation as a Grade A school, a position
10 which it has since retained.

11 M-4 Post War Problems At the end of the Second
12 World War, a second major crisis occurred. The endowments
13 of the Faculty were greatly reduced in value because of
14 inflation, the cost of salaries and other expenditures rose
15 rapidly, there was need for replacement of staff members
16 who had reached retirement age, and for an expansion of
17 staff to take care of the large enrolment of veterans.
18 Until 1940, Dalhousie University had functioned as a priv-
19 ately endowed institution dependent solely upon the tuition
20 fees of the students and income from private endowments or
21 gifts. It is not surprising, therefore, that the Faculty
22 had failed to progress as rapidly as it should have during
23 the depression years of the thirties, and the War period
24 up to 1945. It then faced the tremendous task of recruiting
25 staff at a time when almost all universities were in the
26 same difficulty. The Faculty of Dentistry had similar
27 problems. Partly under the stimulus of War, there had also
28 been a tremendous upsurge of knowledge in the medical
29 sciences and in the practice of both medicine and dentistry.
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The modern university had to provide much more elaborate

1 facilities, not only for teaching, but for research, if it
2 was to obtain suitable staff. It became quite apparent
3 to the University that it must look for substantial govern-
4 ment support if the Faculties were to maintain standards
5 sufficient to continue as accredited institutions of pro-
6 fessional education.

7 Beginning of Provincial Grants

9 M-5 The first provincial grant to support the
10 Faculties of Medicine and Dentistry was made by the Govern-
11 ment of Nova Scotia in 1939-40. Newfoundland made its
12 first grant in 1943, but it was not until 1947 that the other
13 two Maritime Provinces provided any assistance. On rep-
14 resentation from Dalhousie University in that year, the
15 first grant was obtained from the Province of New Brunswick,
16 amounting to \$20,000, and from the Government of Prince
17 Edward Island, amounting to \$5,000 per annum. The grants
18 from Newfoundland and Nova Scotia were increased to \$10,000
19 and \$80,000 respectively. The total grants amounted to
20 \$115,000.

21 M-6 These grants represented a de facto rec-
22 ognition of the position of the two Faculties as the reg-
23 ional Medical and Dental Schools, but no procedure was
24 developed to ensure joint action by the Provinces in asses-
25 sing the requirements and apportioning the costs.

26 M-7 The results of the numerous approaches to
27 the four Governments in search of financial help will be
28 elaborated upon in a later section dealing with finances,
29 following the section on Dentistry (F-1 to F-18).

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M-4

Educational Programmes of the Faculty

M-8 The Dalhousie Faculty of Medicine has several functions in addition to the education of undergraduate medical students, and these must all be considered in making future plans. These several functions, in the order of priority approved by the Faculty of Medicine, are:

(a) The education of undergraduate medical students in the medical sciences and clinical subjects.

(b) The development of medical research in as many fields as possible, within the areas of interest and competence of Faculty members.

(c) The education of undergraduate dental students in the medical sciences, in collaboration with the Faculty of Dentistry.

(d) The education of science graduate students (M.Sc., Ph.D.) in the Medical Science Departments, in collaboration with the Faculty of Graduate Studies.

(e) A limited number of courses for junior or senior science students in the Medical Science Departments e. g. biochemistry, bacteriology, human physiology, in collaboration with the Faculty of Arts & Science.

(f) Aid to the affiliated hospitals in the education of post-graduate medical students in the various clinical specialties, leading to certification or fellowship in the Royal College of Physicians and Surgeons of Canada.

(g) Continuing medical education for general practitioners and clinical specialists in the four Atlantic Provinces.

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priority approved by the Faculty of Medicine, are:

(a) The education of undergraduate medical students

in the medical sciences and clinical subjects.

(b) The development of medical research in as many

fields as possible, within the areas of interest and

(c) The education of undergraduate dental students

in the medical sciences, in collaboration with the fac-

ulty of Dentistry.

(d) The education of science graduate students (M.Sc.,

Ph.D.) in the Medical Science Departments, in collabora-

tion with the Faculty of Graduate Studies.

(e) A limited number of courses for junior or senior

science students in the Medical Science Departments e.

g. biochemistry, bacteriology, human physiology, in

collaboration with the Faculty of Arts & Science.

of post-graduate medical students in the various clini-

cal specialties, leading to certification or fellowship

in the Royal College of Physicians and Surgeons of

(f) Continuing medical education for general practi-

tioners and clinical specialists in the four Atlantic

Provinces.

1 (h) Education and training of other professional
2 and technical personnel, e.g. undergraduate nurses, graduate
3 nurses, phsiotherapists, medical laboratory technicians,
4 pharmacists, dental hygienists, etc. in collaboration with
5 other Faculties and agencies.

6 Recent Developments and Plans

7 M-9 The lines along which the Faculty of Medicine
8 should develop have been given much thought during the past
9 five years. A recent report to the University Senate out-
10 lined the requirements of the Faculty for the next five-
11 year period, 1961-1965. In the period just completed, 1956-
12 1961, the first problem to receive attention had been the
13 recruitment of well-qualified staff. Only a bare minimum of
14 remodelling was done to the existing physical plant. The
15 emphasis was on "men" rahter than "bricks and mortar". Dur-
16 ing this period the annual expenditures for operation in-
17 creased from \$349,524 to \$721,854 and almost all of this
18 amount went towards enlargening the staff and paying better
19 salaries. The increase was made possible through greater
20 financial grants from the four Atlantic Provinces, several
21 grants from Foundations and higher tuition fees. In the
22 same period, research funds from outside agencies grew four-
23 fold to \$320,000 per annum. The cost of remodelling space
24 vacated by the Faculty of Dentistry and the Maritime College
25 of Pharmacy was covered by the Medical Alumni Campaign Fund.
26 Since 1954 the full-time staff of the Medical Science De-
27 partments increased from sixteen to thirty-one, but there are
28 still several vacancies. The full-time staff of the Clini-
29 cal Departments increased from two to twelve, and the part-
30 time staff to 127.

Recent Developments and Plans

The lines along which the Faculty of Medicine should develop have been given much thought during the past five years. A recent report to the University Senate outlines the following developments and plans for the next five year period, 1961-1965. In the period just completed, 1956-1961, the first problem to receive attention had been the recruitment of well-qualified staff. Only a bare minimum of remodeling was done to the existing physical plant. The emphasis was on "men" rather than "bricks and mortar". During this period the annual expenditures for operation increased from \$342,524 to \$421,554 and almost all of this amount went towards enlarging the staff and paying better salaries. The increase was made possible through greater financial grants from the four Atlantic Provinces, several grants from Foundations and higher tuition fees. In the period 1961-1965 the cost of remodeling space is estimated to be \$320,000 per annum. The Faculty of Dentistry and the Maritime College of Pharmacy was covered by the Medical Alumni Campaign Fund. Since 1954 the full-time staff of the Medical Science Department has increased from sixteen to thirty-one, but there are still several vacancies. The full-time staff of the Clinical Departments increased from two to twelve, and the part-time staff to 127.



M-6

M-10 Present Facilities The Faculty of Medicine has no single home, but operates in a number of University buildings as well as the Provincial Pathology Institute and the affiliated teaching hospitals. Appendix A shows the ground plan of the medical campus and its relation to the hospitals and other institutions. Appendix B contains a brief description of each of the Medical School buildings, its functions and future needs. The size of the affiliated teaching hospitals is also discussed. The salient features are summarised here:

(a) The facilities available to the Medical Science Departments are grossly inadequate to provide for the increasing enrolment of students and the rapidly growing research programme of the staff. Except for the Medical-Dental Library built in 1940, the other Medical School buildings date back to 1923, or in the the case of the Forrest Building, to 1886. The teaching laboratories designed for sixty medical and dental students now house eighty-five in those two Faculties as well as students in science and the para-medical professions. Offices and research facilities were originally provided in these buildings for one professor in each of the five departments but the staff now numbers eighteen, with three additional vacancies to be filled. Also requiring space are graduate students in science, research technicians and other staff. There is also a need for larger library facilities and research laboratories for the clinical departments.

(b) The Board of Governors of the University has recognised these needs and has approached the construction

Present Facilities The Faculty of Medicine

is no single home, but operates in a number of University buildings as well as the Provincial Pathology Institute and the various other buildings. The ground plan of the medical campus and its relation to the hospitals and other institutions. Appendix H contains a brief description of each of the Medical School buildings, its functions and future needs. The size of the affiliated teaching hospitals is also discussed. The salient features are summarized here:

(a) The facilities available to the Medical

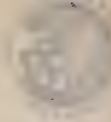
Science Departments are grossly inadequate to provide for the increasing enrolment of students and the rapidly growing research programme of the staff. Except for the Medical buildings date back to 1929, or in the case of the West Building, to 1886. The teaching laboratories designed for sixty medical and dental students now house eighty-five in those two buildings as well as students in science and the para-medical professions. Offices and research facilities were originally provided in these buildings for one professor in each of the five departments and the staff now numbers eighteen, with three additional vacancies to be filled. The present gross and productive capacity for science, research technicians and other staff. There is no provision for the expansion of the University has recognized these needs and has approved the construction

1 of a new Medical Building if the necessary funds, estimated
2 at four and a half million dollars can be obtained. The
3 present Forrest Building and Medical Sciences Building will
4 be required for the Department of Biology, the Institute
5 of Oceanography and the Faculty of Health Professions.

6 (c) The Departments of Pathology and Bacteriology
7 have excellent new facilities, adequate for an enrolment of
8 100 medical and dental students and for the staff required
9 to teach them. These quarters were provided in 1961 by the
10 Province of Nova Scotia in the enlarged Pathology Institute.

11 (d) One of the striking features, upon which
12 visitors to Dalhousie comment favourably, is the very con-
13 venient geographic location of the Medical School buildings
14 in relation to most of the affiliated hospitals, the Vic-
15 toria General, Grace Maternity, Children's, Halifax Conva-
16 lescent and the Nova Scotia Rehabilitation Centre. The
17 Halifax Infirmary is only a few blocks east and Camp Hill
18 Hospital about the same distance north. The Armed Forces
19 Hospital in the northern part of the City is also associated
20 with the Medical School. As a group, they provide convenience
21 in medical teaching facilities which is difficult to equal.

22 (e) Most of the hospitals in Halifax have recen-
23 tly enlarged or are now planning to enlarge their facilities.
24 The total capacity of all of these institutions will reach
25 approximately 2600 beds by 1965, if present plans are
26 carried out. The teaching units in these hospitals, where
27 all patients are under the direct care of University teach-
28 ers, will have a capacity of 750 beds. These units will be
29 adequate to permit the training of 75 medical students in
30 the senior year. The Association of Canadian Medical



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The total capacity of all of these institutions will reach

approximately 2000 beds by 1965, in present plans are

carried out. The teaching units in these hospitals, where

all patients are under the direct care of University teach-

adequate to permit the training of 75 medical students in

the senior year. The Association of Canadian Medical

1 Colleges recommends a minimum of 10 beds per senior student
2 in the general teaching hospitals, excluding those for
3 military and D.V.A. patients.

4 (f) It is vitally important that these teaching
5 units be maintained under any new or expanded plan for
6 medical services insurance.

7 (g) The present Public Health Clinic will pro-
8 vide adequate research facilities for the clinical depart-
9 ments when the out-patient services in obstetrics and pae-
10 diatrics move to the new Grace Maternity and Children's
11 Hospitals. The cardio-pulmonary research unit alone will
12 cost more than \$100,000 and the total for remodelling and
13 equipping this building is estimated at \$250,000.

14 Undergraduate Medical Education

15 M-11 The curriculum of Dalhousie Medical School
16 has been thoroughly reviewed by the Faculty on several
17 occasions in recent years and it is fully in line with mo-
18 dern trends in education which the Faculty consider to be
19 sound.

20 M-12 The first two undergraduate years at Dal-
21 housie are devoted to the pre-medical sciences with only an
22 introduction to clinical studies. The third and fourth
23 years are almost wholly devoted to the clinical subjects
24 and in the fourth year the student spends most of his time
25 in the teaching units of the hospitals as a clinical clerk.
26 Except for a few details, the programme is similar to the
27 more or less standard plan followed by most accredited
28 Canadian and American medical schools.

29 M-13 One major difference is that Dalhousie re-
30 quires only three years of pre-medical education in an Arts &

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1 Science Faculty (after Junior Matriculation) before admis-
2 sion to Medicine. Some universities in Canada and many in
3 the U.S.A. require a Bachelor's degree, or four years from
4 junior matriculation.

5 M-14 The second difference is that Dalhousie
6 does not grant the M.D. degree until students have completed
7 an internship in a University-selected hospital or hospitals.
8 Most other Canadian medical schools, except two in the
9 Province of Quebec, grant the degree at the end of four
10 years in the Medical School, but the licensure regulations
11 require an internship before the graduate is professionally
12 qualified. The Dalhousie graduate obtains the degree and
13 license at the same time. The duration of the medical
14 training is therefore the same as in other Canadian schools.
15 The Faculty considers it a University responsibility to
16 retain general supervision over the internship in order to
17 ensure that every student obtains a balanced rotation in-
18 cluding Medicine, Surgery, Obstetrics and Paediatrics.
19 Graduates from other medical schools who seek their own
20 internship cannot be assured of such a complete rotation
21 even in hospitals approved for internship by the Canadian
22 Medical Association. Dalhousie University intends to con-
23 tinue its system of granting the medical degree after the
24 internship. We would request the Royal Commission to ensure
25 that any of its recommendations relating to medical edu-
26 cation take into account the fact that Dalhousie and two
27 other Canadian Universities have a five-year medical course,
28 including internship, while others have a four-year course,
29 excluding internship. In the past the phrasing of regula-
30 tions as though the four-year pattern was the only one, has

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tions as though the four-year pattern was the only one, has



1 resulted in problems for this University and for our graduates.

2 M-15 Reference has been made to the teaching units

3 and teaching beds in the affiliated hospitals. It is im-

4 portant to emphasize that these are absolutely essential

5 to modern medical education. Medicine has become much more

6 scientific and medical education has improved greatly com-

7 pared with the system of apprenticeship of the last century.

8 However, medical education still has to retain the best

9 elements of the apprenticeship system. The private patients

10 of another physician may be used effectively by a teacher

11 to demonstrate an unusual condition or for other specific

12 reasons. Nevertheless, this type of teaching by demon-

13 stration does not alone provide an adequate basis for a

14 medical education. The student must be incorporated into a

15 group of clinical clerk-intern-resident-staff member, each

16 assigned and required to accept responsibility commensurate

17 with his level of training. In a hospital where every

18 patient has his own doctor, modern clinical teaching is

19 impossible. There must be a nucleus of "closed wards" or

20 "teaching units" in which all the patients are under the

21 care of the active staff and their graduate and undergraduate

22 students. If this system of closed teaching units is not

23 fully preserved under any proposed voluntary or government-

24 financed insurance plan, medical education will rapidly

25 deteriorate.

26 M-16 The importance of the teaching unit to the

27 hospital as well as to the medical school is evidenced by

28 the letter contained in Appendix C which includes the fol-

29 lowing resolution from the Board of Commissioners of the

30 Victoria General Hospital:

and teaching beds in the affiliated hospitals. It is im-

possible to separate the teaching and clinical work.

It is essential that the teaching and clinical work be

integrated and that the teaching and clinical work be

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"THAT, UNDER ANY FORM OF UNIVERSAL MEDICAL CARE PROGRAMME, THE TEACHING ASPECTS AND RESPONSIBILITIES OF HOSPITALS BE PROTECTED AND MAINTAINED AS EXISTING OR IMPROVED STANDARDS. THIS RESOLUTION IS TO BE FORWARDED TO THE DEAN OF MEDICINE, WITH THE REQUEST THAT IT BE INCLUDED IN THE UNIVERSITY BRIEF ON EDUCATION."

M-17 Student Enrolment and the Supply of Medical Doctors Undergraduate medical education must take priority over all other functions of the Faculty of Medicine listed in a preceding section (Paragraph M-8). The Faculty of Medicine has two duties, to provide educational opportunities for the young men and women of the four Atlantic Provinces who wish to study medicine, and, incidentally, to provide most of the physicians who will practice in this region.

M-18 More than 85 percent of the English-speaking students of the Atlantic Provinces who entered medicine during the past ten years enrolled at Dalhousie (Appendix D).

M-19 Approximately 70 percent of the medical doctors entering practice in the four provinces are Dalhousie graduates (Appendix E).

M-20 Shortage of Physicians It has been obvious for many years, to all who have given the matter thought, that there is a shortage of physicians in the four Atlantic Provinces. Convincing statistics were presented in a Government Report in 1950. If one applies any reasonably acceptable ratio of what is thought to be an adequate proportion of doctors to population, one invariably arrives at



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1 the conclusion that there is a shortage (Appendix F). How
2 large this is, depends upon which of the several yard-
3 sticks is applied, all of which are a little dubious as to
4 accuracy. It must be emphasised, however, that even the
5 lowest estimate of the shortage reported in the Survey of
6 Health Facilities (1) was

7 (1) Stewart, C.B. - Survey of Health Facilities
8 and Services in Nova Scotia,
9 1949-1950: Province of Nova
10 Scotia Report.

11 a larger number of doctors than could have been placed in
12 practice in Nova Scotia with assurance of a reasonable
13 livelihood. In other words, an estimate of the shortage
14 based on how many communities in Nova Scotia need and are
15 prepared to support a doctor, or which could support more
16 than they now have, would be much smaller than an estimate
17 based on providing an ideal level of service according to
18 any known standard. The public and the medical profession
19 both tend to make estimates of the shortage of doctors on
20 the very practical basis of counting communities capable of
21 supporting more. However, any system which will provide
22 greater medical insurance coverage, or which subsidises
23 physicians in "under-doctored" areas will result in the
24 larger estimates of the shortage becoming more "realistic"
25 than they were in the past.

26
27 M-21 Factors Influencing Shortage Many writers
28 and speakers have speculated concerning the reasons for the
29 shortage of physicians here and in Canada generally. Some
30 without any knowledge of the facts have placed the blame

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shortage of physicians here and in Canada generally. Some

without any knowledge of the facts have placed the blame



1 on the medical profession, which was suspected of having
2 ulterior motives in keeping the supply low so that incomes
3 would be high. Nothing could be farther from the truth.
4 Only two factors have placed limitations on the education
5 of doctors at Dalhousie. The first was the size of the
6 laboratories in the medical science departments, in which
7 almost all of the classes of the first two years are taught.
8 Only sixty students could be accommodated from 1923 to 1945,
9 fifty in medicine and ten in dentistry. During that whole
10 period, every qualified applicant from the four provinces
11 could be accepted, and many from other areas were also
12 trained. So the second and most important limiting factor
13 clearly was the small number of students wishing to study
14 medicine. Only in the immediate post-war period did Dal-
15 housie have to curtail admissions of Atlantic Province
16 students, and an effort was made to prevent this by crowd-
17 ing additional benches and equipment for ten more students
18 into the existing laboratories. The highly qualified
19 students were admitted, but many good average students were
20 refused. At no time did the medical profession suggest a
21 limitation of enrolment, but there was consistent pressure
22 by individual doctors on the University to take more than
23 could be accommodated.

24 M-22 Recent Trends in Student Enrolment The post-
25 war influx of students subsided in 1955, as in all other
26 Canadian and American medical schools, and Dalhousie has
27 had sufficient room for all qualified Atlantic Province
28 students from 1956 to date. In fact, the first year clas-
29 ses were kept up to their usual size by accepting more
30 students from the West Indies, the U.S.A. and other countries.

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22 Canadian and American medical schools, and Dalhousie had
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25 dents were kept up to their usual size by accepting more
26 students from the West Indies, the U.S.A. and other countries.



1 The trend in applications is now going upward again in a
2 sharp slope. The influx of Arts & Science students which
3 began three or four years ago reached the professional
4 schools in 1960 and 1961. It was still possible to accept
5 all well-qualified Atlantic Province students in September
6 1961, but if the present upward trend in applications con-
7 tinues, a considerable number will have to be rejected by
8 1962, or at latest 1963, or no foreign students accepted.
9 The Faculty considers it desirable that some foreign
10 students should be admitted.

11 M-23 Inadequate Date for Planning When the num-
12 ber of applicants for admission to medical schools began
13 to fall a few years ago, some very pessimistic predictions
14 were made and there was much guessing at the explanations.
15 The truth is that there are no valid standards for estima-
16 ting how many students should be expected to enter medicine
17 from the population of 1.9 millions in the Atlantic Provinces.
18 Several recent articles have deplored the reduction in
19 numbers as compared with those of the post-war period.
20 Obviously there has been a reduction, but the post-war
21 period was a very abnormal one to use as a base-line for
22 comparison. At that time the back-log of six years of
23 veterans was superimposed on the normal number applying
24 for admission. In fact, most statistics grossly over-esti-
25 mate the numbers seeking a medical education during that
26 period. There was no central clearing-house where records
27 were analyzed by name and most students, particularly in
28 the lower academic class, submitted score of applications
29 each year to institutions all across the continent.

30 M-24 A study is now being made of the Dalhousie

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sharp slope. The influx of Arts & Science students which



1 records to determine the number of applicants from these
2 four Provinces in relation to population. If the results
3 seem to reveal anything of interest, they will be forwarded
4 to your Commission. One cannot be too optimistic because
5 there seems to be no "normal" period with which a comparison
6 can be made. The post-war period had an unusually large
7 number of applicants, but preceding it were the war and the
8 depression years, when applications for admission to medical
9 schools were abnormally low.

10 M-25 Need for Medical Buildings In any event,
11 the experience at Dalhousie shows that the two limiting
12 factors on the supply of doctors has been the inadequacy
13 of facilities and the small number of qualified students.
14 The latter seems to be gradually correcting itself although
15 perhaps more slowly than is desirable. The former could be
16 solved by providing funds to the University to build larger
17 teaching facilities and to staff them. Dalhousie has no
18 desire to place a limitation on future enrolment simply
19 because of inadequate facilities.

20 Expansion of Dalhousie Medical School
21

22 M-26 In the Survey of Health Facilities and
23 Services of Nova Scotia in 1949-1950 (1), it was estimated
24 that Dalhousie should be graduating sixty-five students per
25 year to meet, at least in part, the shortage then existing
26 and to take account of the growth in population, loss of
27 doctors by death and retirement and their transfer to and
28 from this region. It is now estimated by the Faculty that
29 at least seventy-five students should be enrolled in first
30 year as soon as facilities can be provided. The trends
would seem to indicate that sufficient students will be

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1 seeking admission and there is no question of the need
2 for more physicians in the area. This need will increase
3 as voluntary medical insurance plans grow, and particularly
4 if comprehensive Government-financed health insurance were
5 to be introduced. It is estimated that under such a plan
6 there might be a 50 percent increase in demand for medical
7 services in the Maritime Provinces and even more in New-
8 foundland. A corresponding increase would be required in
9 the number of medical graduates. Since the Faculty of
10 Medicine at Dalhousie is the only one in this region, the
11 shortage of practitioners must be considered as well as the
12 needs for providing students with professional education in
13 the field of their choice. For both of these reasons an
14 increase in the present enrolment is desirable before 1965.

15 M-27 It is therefore planned that the immediate
16 goal of Dalhousie Medical School will be the enrolment of
17 seventy-five students in the first year class and the pro-
18 vision of staff and facilities on a corresponding scale.
19 In the Medical Building now being planned, space is being
20 provided for sevnty-five medical and twenty-five dental
21 students, but the rooms will be so designed that the
22 classes of the two Faculties can be separated and one hun-
23 dred medical students and fifty dental students accommodated.
24 The Faculty of Medicine would prefer a class of approximate-
25 ly seventy-five rather than the larger number. It is anti-
26 cipated, however, that there may be a period when one hun-
27 dred medical students will have to be accommodated while
28 plans are being made for another medical school in the
29 Atlantic Region.

30 M-28 Number of Medical Schools One suggestion

existing situation and there is no question of the need

for more physicians in the area. This need will increase

as the population of the area continues to grow.

It is therefore recommended that the number of

physicians be increased to meet the needs of the

community.

The following are the reasons for this recommendation:

1. A corresponding increase would be required in

the number of medical graduates. Since the Faculty of

Medicine at Dalhousie is the only one in this region, the

shortage of practitioners must be considered as well as the

needs for continuing education.

2. The field of their choice. For both of these reasons an

increase in the present enrollment is desirable before 1965.

It is therefore planned that the immediate

goal of Dalhousie Medical School will be the enrollment of

seventy-five students in the first year class and the pro-

vision of staff and facilities on a corresponding scale.

In the Medical Building now being planned, space is being

provided for seventy-five medical and twenty-five dental

students, but the rooms will be so designed that the

classes of the two faculties can be separated and one hun-

dred medical students and fifty dental students accommodated.

The Faculty of Medicine would prefer a class of approximately

seventy-five students.

It is anticipated, however, that there may be a period when one hun-

dred medical students will have to be accommodated while

plans are being made for another medical school in the

area.

It is suggested that the following be considered:

1. The Faculty of Medicine should be increased to



1 which is almost certain to be presented to the Royal
2 Commission is that more medical schools be established in
3 Canada. When 85 percent of the English-speaking students
4 from the Atlantic Provinces are now being accommodated at
5 Dalhousie, and the few who went elsewhere in the last five
6 years could have been admitted here, it would seem pre-
7 mature to suggest the establishment of another medical
8 school in the Atlantic Provinces until Dalhousie is used
9 to its fullest capacity. Another school, if it were of a
10 capacity of less than forty students per year, would be
11 very costly and inefficient, and it should preferably have
12 more than fifty. There are not that many students seeking
13 admission to medicine from any province in this area. The
14 cost per student per year is certain to be at least \$3,500
15 in a small new school and might be much more. Dalhousie's
16 cost is now approximately \$3,200. The initial cost of
17 buildings would be three or four million dollars, excluding
18 hospitals. The shortage of trained staff must also be con-
19 sidered. It seems reasonable to suggest therefore that the
20 facilities at Dalhousie be developed to their maximum.

21 After the enrolment reaches seventy-five in first year and
22 begins to move toward one hundred, consideration should be
23 given to establishing another medical school. At that time
24 Dalhousie will assist in any possible way to further such
25 a development. The Faculty would prefer an annual class
26 of about seventy-five. However, unless there is a success-
27 ful programme for recruitment of more students into medicine
28 and increased financial support for them, it will probably
29 be quite a few years before the expanded facilities at Dal-
30 housie will be used to their fullest extent.



which is almost certain to be presented to the Royal

Canada. When 85 percent of the English-speaking students from the Atlantic Provinces are now being accommodated at Dalhousie, and the few who went elsewhere in the last five years could have been admitted here, it would seem proper

to suggest the establishment of another medical school in the Atlantic Provinces until Dalhousie is used to its fullest capacity. Another school, if it were of a capacity of less than forty students per year, would be

very costly and inefficient, and it should preferably have more than fifty. There are not that many students seeking admission to medicine from any province in this area. The cost per student per year is certain to be at least \$5,000 in a small new school and might be much more. Dalhousie's cost is now approximately \$8,500. The initial cost of

buildings would be three or four million dollars, excluding hospitals. The shortage of trained staff must also be considered. It seems reasonable to suggest therefore that the facilities at Dalhousie be developed to their maximum.

After the enrolment reaches seventy-five in first year and begins to move toward one hundred, consideration should be given to establishing another medical school. At that time Dalhousie will assist in any possible way to further such

a development. The Faculty would prefer an annual class of about seventy-five. However, unless there is a successful programme for recruitment of more students into medicine and increased financial support for them, it will probably

be quite a few years before the expanded facilities at Dalhousie will be used to their fullest extent.



Quality of Medical Students

M-29 Of great concern has been recent suggestions that there has been a reduction in the academic quality of applicants for admission to medical schools. Most of these statements are based on one published study of academic standing in their pre-medical courses of the first year medical students of U.S. schools (1). The conclusion was that only half as many students enrolling in medicine in recent years had an A average in pre-medical studies as in the period 1950-1951. This is, of course, a gross mis-use of statistics, although it seems to have been accepted by most medical educators without much question. The fact is that with few exceptions, only veterans were admitted to Canadian or American medical colleges from 1945 to 1949. In 1950 and 1951 the "civilians" were again admitted and these included an unusually high proportion of top-ranking students, some with higher degrees. They had waited until the veteran classes passed through, assured of their own chances of admission later. The poorer students permanently transferred into other fields of study, rather than take a chance on waiting one or two years in the dubious likelihood of getting into a medical school.

M-30 It may well be true that there are fewer brilliant students choosing medicine now, but such statistics as have been published do not prove it. The impression of teachers at Dalhousie is that our classes show no sign of deterioration. An analysis of the academic records for the last twenty years is almost complete now, and no significant trends are evident.

(1) Turner, E.L., Wiggins, W.S., Shepard, G.R.,

statements are based on one published study of academic standing in their pre-medical courses of the first year medical students of U.S. schools (1). The conclusion was that only half as many students enrolling in medicine in recent years had an A average in pre-medical studies as in the period 1950-1951. This is, of course, a gross mis-use of statistics, although it seems to have been accepted by most medical educators without much question. The fact is that with few exceptions, only veterans were admitted to Canadian or American medical colleges from 1945 to 1949. In 1950 and 1951 the "civilian" were again admitted and these included an unusually high proportion of top-ranking students, some with higher degrees. They had waited until the veteran classes passed through, assured of their own

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1 Springall, A.N. and Tipner, A.: Medical
2 Education in the United States and Canada,
3 56th Annual Report. J.A.M.A. 161, 1956, p.
4 1659. (By the Council on Medical Education
5 and Hospitals, A.M.A.)
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Financial Support for Students

M-31 Nevertheless, it is quite obvious that the highly qualified student who is in the top third of his class in Arts & Science, is at a decided financial disadvantage if he chooses to study medicine. If he goes on to a Masters and Ph.D. degree he can be reasonably sure of a research fellowship of approximately \$2,000 per year, enough to cover tuition and living costs during his training period. His only expense will have been during the undergraduate years in science. On the contrary, if he goes into medicine, he will pay higher tuition than in science and will have a longer course of about two years. It costs the medical student a minimum of \$1,600 a year for four years in the medical school to cover tuition and living expenses, a total of \$6,400. There is almost no likelihood of him getting a bursary or fellowship. The science student of high academic standing will receive \$2,000 a year for the three or four years of M.Sc. and Ph.D. training, a total of at least \$6,000. The differential is at least \$12,000 in favour of the science student. It would seem reasonable to assume that some students who would prefer to study medicine may have to choose another field of science for financial reasons.

M-32 During the past two years, the Province of Newfoundland has provided financial assistance to medical students at the rate of \$1,200 per year. The student must serve two years after graduation in an area to which he is assigned and an additional two years practising in any community he may choose in the Province which may include



1 post-graduate training in St. John's. The introduction of
2 this plan has been followed by an increase in the number of
3 Newfoundland students entering medicine at Dalhousie.
4 Whether this is the chief cause for the increase is not
5 known, since it coincides with the increase in general
6 enrolment in Arts & Science.

7 M-33 Length of Medical Course The length of the
8 medical course is considered by some to be a major obstacle
9 to the recruitment of students. It is necessary to consider
10 here the tremendous growth in medical knowledge, the in-
11 tricacy of new diagnostic and therapeutic procedures and the
12 sheer volume of facts with which the future physician must
13 not only become acquainted, but must learn to understand,
14 to reason with and to use. Under such circumstances any
15 suggestion that the period of study in medicine can be
16 reduced cannot be considered very seriously. Nevertheless,
17 it might be possible to shorten the time between entry to
18 medicine and graduation without shortening the actual period
19 of study. A lengthening of the academic year would achieve
20 this end. In its favour is the argument that an expensive
21 teaching plant should be used by students for a longer per-
22 iod each year. Certainly in its favour is the fact that
23 it would shorten the period of medical education. A stu-
24 dent spends at least eight years of his life in pre-medical,
25 medical and internship training, and an additional four
26 years if he takes post-graduate training in a specialty.
27 In the pre-medical course he is in University only seven
28 months of the year. It should be quite possible to compress
29 the same work into two years if the University had a longer
30 session. In the Medical School the academic year is longer,

post-graduate training in St. John's. The introduction of this plan has been followed by an increase in the number of Newfoundland students entering medicine at Dalhousie. Whether this is the chief cause for the increase is not known, since it coincides with the increase in general enrolment in Arts & Science.

Length of Medical Course M-33 The length of the medical course is considered by some to be a major obstacle to the recruitment of students. It is necessary to remember here the tremendous growth in medical knowledge, the intensity of new diagnostic and therapeutic procedures and the sheer volume of facts with which the future physician must not only become acquainted, but must learn to understand, to reason with and to use. Under such circumstances any suggestion that the period of study in medicine can be reduced cannot be considered very seriously. Nevertheless, it might be possible to shorten the time between entry to medicine and graduation without shortening the actual period of study. A lengthening of the academic year would achieve this end. In its favour is the argument that an expensive four each year. Certainly in its favour is the fact that a student spends at least eight years of his life in pre-medical, medical and internship training, and an additional four years if he takes post-graduate training in a specialty. In the pre-medical course he is in university only seven months of the year. It should be quite possible to compress the same work into two years if the University had a longer



1 being nine months. It might be possible to give the
2 present four-year course in three calendar years of eleven
3 months, with one month's holiday. However, such a method
4 of shortening the length of the period between admission
5 and graduation could not be adopted by Dalhousie University
6 under present conditions. It is estimated that half the
7 medical students would be unable to attend at all, if they
8 did not have three months in which to earn a part of their
9 educational costs.

10 M-34 A system of financial support for pre-medical
11 and medical students, adequate in amount to preclude the
12 necessity of summer earnings, would therefore be a first
13 requirement toward compressing the course. This assistance
14 would have to be of the order of \$2,000 each year. Dal-
15 housie medical students now require a minimum of \$1,600
16 and more would be required because of the longer academic
17 year.

18 M-35 Effect on Post-Graduate Education If a
19 system of support similar to that used in Newfoundland
20 were adopted and graduates who had received Government aid
21 as students were required to repay it in service, it is
22 suggested that such service be provided on a national rather
23 than a provincial basis. The graduate could then be as-
24 signed to any medically need area of Canada, to the mili-
25 tary medical service, Indian health or immigration, pro-
26 vincial public health or other services. In the last two
27 years, if four years of service were required, the graduate
28 should be permitted to practice in any part of the country
29 and in particular, it would be important that he be allow-
30 ed to do post graduate work anywhere in Canada. In fact,

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months, with one month's holiday. However, such a method
of shortening the length of the period between admission
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and in particular, it would be important that he be allow-
ed to do post graduate work anywhere in Canada. Indeed,



careful consideration should be given to the desirability of having such scholarships completely free of any service requirement.

M-36 Grants to Medical School In order to compress the medical course into a shorter period, the second requirement as well as assistance to students, would be financial support to the University to allow at least a 35 percent increase in the teaching staff of both the pre-clinical and clinical years. Professors now depend heavily on two of the three summer months, when students are absent, to get their research done. If the present year of three terms were extended to four terms, no staff member should be expected to teach more than three. By rotating staff in each Department it should be possible to provide research opportunities as at present if the staff was increased by one third.

M-37 Retention of Internship It is not considered practical or desirable to shorten or eliminate the twelve months of internship. This is the time when the student learns to apply his basic knowledge to clinical problems, and of paramount importance, he learns to take a reasonable amount of responsibility. It should be emphasized again that it is only in a teaching unit, where such responsibility is delegated by the staff, that the best level of medical education can be achieved.

M-38 General Practice Internship The College of General Practice has recommended a second year of internship. This has much to commend it but we hesitate to suggest any increase in the length of the training programme. It would seem more practical to have a general practice pre-

careful consideration should be given to the desirability of having such scholarships completely free of any services

Transfer to Medical School In order to com-

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ceptorship with the new graduate after internship, going into practice with an experienced general practitioner. It has been suggested that the general practitioner might keep the new graduate in his practice for two years, the first under supervision and the second in full charge while the senior practitioner himself took a year of further post-graduate study at a teaching hospital.

Desirability of High Priority for Medical Education

M-39 There is now a ratio of 1,013 persons per physician in Nova Scotia. The Canadian average is 879. In order to meet this national average in the four Atlantic Provinces would require more than six hundred additional doctors. Assuming that the recent past is a trustworthy guide, one would expect Dalhousie to provide about sixty to seventy percent of this number. In recent years Dalhousie has been graduating an average of fifty-two per year, of whom approximately thirty-five remain in this area or return here after post-graduate training. The estimated requirement of new doctors in the Atlantic Provinces to replace loss by death, retirement and emigration and to provide for the population at its present rate of about ten per year. Added to this in recent years has been considerable immigration. The ratio of population per physician in Nova Scotia has improved from 1,277 persons per physician in 1949, to 1,103 in 1960, and gains have been made in the other three provinces as well. By increasing the graduating class at Dalhousie to seventy-five, the shortage of doctors would be decreased at the rate of about twenty-five per year, assuming two-thirds of the graduates

ceptorship with the new graduate after internship, going into practice with an experienced general practitioner. It has been suggested that the general practitioner might keep under supervision and the second in full charge while the senior practitioner himself took a year of further post-graduate study at a teaching hospital.

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1 remain in these provinces. Ten years after Dalhousie
2 classes reach seventy-five graduates per year, the shortage
3 would be appreciably reduced, by 250 more Dalhousie gradu-
4 ates and about eighty immigrants. This would reduce, but
5 not eliminate the shortage of six hundred in the region as
6 compared with the Canadian average.

7 M-40 It cannot be too strongly urged that the
8 Royal Commission examine the implications of the above
9 figures very carefully. Plainly stated, if the Federal or
10 Provincial Governments were to provide money now to permit
11 Dalhousie University to enlarge its facilities and if they
12 were to begin now a system of student support which would
13 bring more students into medicine, it would take at least
14 three years to plan and construct the teaching facilities
15 and obtain the staff at Dalhousie. Since three years of
16 pre-medical education are required, the University might,
17 with financial assistance, be ready for the increased en-
18 rolment when it began. It would be unlikely, however, that
19 financial assistance for students would result in an im-
20 mediate upsurge in numbers. It would be five years at least
21 and more likely seven or eight after introduction of a
22 scholarship plan before the enrolment would reach eighty
23 to eighty-five in first year medicine, a level that might
24 permit the graduation of seventy-five. It would be five
25 years later before this larger class would graduate. In
26 other words, it would take at least ten years, and more
27 likely twelve or thirteen, for the Atlantic Provinces to
28 reach an optimum level of medical graduates and, as al-
29 ready shown, it would take about ten years more after that
30 to bring this area up toward, but not yet to, the Canadian
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likely twelve or thirteen, for the Malawian provinces to

reach an optimum level of medical graduates and, as a

ready shown, it would take about ten years more after that

to bring this area up towards, but not near to, the Canadian

average in population-physician ratio.



1 M-41 Add to this problem the obvious fact that
2 the subsidization of physicians in under-doctored areas,
3 the provision of medical services insurance at Government
4 expense for the indigent and elderly, or the adoption of a
5 medical insurance plan covering the whole population would
6 each in varying degree result in a demand for more medical
7 services in Nova Scotia, and the whole Atlantic area. There
8 is some strongly suggestive evidence, although not clear-
9 cut, that a fully insured population in the three Maritime
10 Provinces, excluding Newfoundland, might demand at least
11 fifty percent more individual medical service than they did
12 ten years ago when the Canadian Sickness Survey was carried
13 out. No data of more recent origin are available, but
14 there is clear evidence that the population insured under
15 Maritime MedicalCare is receiving 3,400 physicians' services
16 per 1000 population when the level for the whole province
17 is about half that figure. It was about 1,500 in the
18 Maritimes in the 1950-1951 period of Canadian Sickness Sur-
19 vey and several insured populations at that time had about
20 50 percent more medical services, approximately 2,100 to
21 2,300 physicians' services per 1000.

22 M-42 The Faculty of Medicine of Dalhousie Uni-
23 versity respectfully appeals to the Royal Commission that
24 you ensure that the provision of more adequate numbers of
25 well-qualified physicians be started immediately through
26 support to universities and to pre-medical and medical
27 students, and that extension of medical care services be
28 carried out on a gradual basis, beginning only with the more
29 pressing needs. Subsidization of doctors in areas of low
30 average economic status and provision of medical insurance

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pressing needs. Subordination of doctors to areas of low



1 for the indigent would seem to be two obvious methods.
2 If a complete medical services insurance plan is introduced
3 within the next few years there will not be nearly enough
4 doctors to operate it effectively. The physicians in this
5 province are for the most part carrying an excessively
6 heavy practice load now. To increase this will result in
7 deterioration of the present service, with resultant lower-
8 ing in the prestige and trust accorded the doctor, which,
9 in turn, will mean a reduction in the number of students
10 attracted into the profession. We think the recruitment
11 and education of doctors should precede the introduction of
12 any extensive medical insurance plan by at least ten years
13 and preferably longer.

14 M-43 Quality of Immigrant Doctors One obvious
15 solution to the shortage of doctors, apart from educating
16 more Canadians, is by immigration. It is strongly recom-
17 mended that the Royal Commission study carefully the re-
18 cords of the Medical Council of Canada and the Provincial
19 Medical Boards, also the results of the Educational Council
20 for Foreign Medical Graduates which show extremely high
21 failure rates among the graduates of many foreign medical
22 schools. An article in the Journal of Medical Education (1)
23 by Dr. J.M. Weir of the Rockefeller Foundation clearly shows
24 that except in the United Kingdom, the Scandinavian coun-
25 tries, the U.S.A. and Canada, the level of medical education
26
27 (1) Obstacles to Medical Education at the International
28 Level. John M. Weir, M.D. J.A.M.A., Vol. 173, No. 13.
29 P. 1451-1453.

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1 is appallingly low. The countries with the greatest excess
2 of doctors willing and anxious to emigrate have, in general,
3 the poorest system of medical education. In some instances
4 an M.D. coming to this country to take care of patients im-
5 mediately as a hospital intern has no more bedside clinical
6 experience than one of our second year medical students.

7 M-44 No doubt some of the shortage of doctors must
8 be met by immigration but better methods should be evolved
9 for the clinical education of these immigrants, or the medi-
10 cal service to Canadians will deteriorate. As a University,
11 our concern on this matter is with the inevitable affect on
12 recruitment of Canadian students into medicine, but we are
13 also keenly aware of our responsibility to advise against
14 a course which might have an ill-effect upon the public
15 health of this country.

16 The Supply of Medical Teachers

17 M-45 Medical Sciences The problem of obtaining
18 the best qualified medical teachers requires careful consi-
19 deration. There are far too few men entering the medical
20 sciences. Most of the prospective students considering medi-
21 cine think only of medical practice as a goal. Students do
22 not realize the tremendously important role of the medical
23 scientist in medical education and research. Inadequate sal-
24 aries in most universities, including Dalhousie, make it
25 unlikely that we will attract nearly enough of the scien-
26 tists interested in biology and chemistry into the medical
27 sciences of biochemistry, physiology, pharmacology, bacterio-
28 logy, anatomy, pathology, etc. Industry and Government
29 service attract many of the trained men.

30 M-46 Part-Time Clinical Teachers In the clinical

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...forest system of medical education. In some instances
...M.D. coming to this country to take care of patients im-
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...not realize the tremendously important role of the medical
...sciences in most universities, including Dalhousie, where it
...is unlikely that we will attract nearly enough of the sci-
...entists interested in biology and chemistry into the medical
...sciences of biochemistry, physiology, pharmacology, bacteri-
...ology and other fields.
...service attract many of the trained men.
...Part-Time Clinical Teaching In the medical



1 fields the problems are even more acute. There has been a
2 great dependence upon the practising specialist or general
3 practitioner to do the clinical teaching of medical students.
4 At present Dalhousie has only twelve full-time teachers in
5 the clinical departments to teach the last two years of the
6 undergraduate course, the internship year and the four years
7 of specialty training. More than 125 doctors in Halifax
8 are also doing clinical teaching on a part-time basis in the
9 affiliated hospitals. Without the unselfish devotion of
10 this large number of practising doctors in the City of
11 Halifax who, until very recent years, carried on all of
12 the clinical teaching, and still bear a very large share of
13 it, the University could not have established and maintained
14 a programme of medical education and could not do so now.
15 Their teaching was often done in the past for no financial
16 remuneration and today the average honorarium is just over
17 \$500 per year although many devote a third of their time
18 and some half-time to hospital and teaching duties. The
19 University recognises this great contribution and is grate-
20 ful for it. We suggest, however, that the public of these
21 four Provinces owes a debt to these men on which some pay-
22 ment is long overdue.

23 M-47 Relation of Teaching and Patient Care In
24 addition to teaching and research, all members of the staff
25 of the clinical departments, both full-time and part-time,
26 have heavy responsibilities for the care of patients in the
27 teaching wards of the affiliated hospitals. It is impossible
28 to draw a clear-cut distinction between teaching and clinical
29 care on a teaching ward, and in some instances, between
30 clinical research and clinical care. The roles of the



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 great development in the clinical departments to reach the last two years of the
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1 Medical School and the teaching hospitals are therefore
2 inextricably intermixed. As the hospitals are increased
3 in size, a larger and larger proportion of the patients
4 referred from other areas of the Province, as well as the
5 indigent patients from Halifax, are cared for without pay-
6 ment to the doctor in the wards of the Victoria General
7 and the other hospitals. Unless some method is found to
8 pay the doctors who care for these indigent patients and
9 at the same time teach medical students and specialists-in-
10 training, we cannot hope to attract enough new doctors to
11 Halifax to provide the increased volume of care in the
12 larger hospitals and to teach the medical students. There
13 is not enough private consulting practice to support all of
14 the necessary specialists in this medical centre.

15 M-48 Full-Time Clinical Teachers During the past
16 decade Canadian medical schools and affiliated teaching hos-
17 pitals have progressively increased the number of full-time
18 teachers in the clinical departments. Such a teacher is a
19 graduate in medicine who had usually had extensive post-
20 graduate training in some particular specialty for five or
21 six years, including teaching and research. Most have
22 successfully completed the difficult examination to become
23 fellows of the Royal College of Physicians and Surgeons of
24 Canada. The large volume of clinical teaching in the under-
25 graduate and post-graduate fields, the growth of clinical
26 research, the complex administration of a modern teaching
27 hospital and many other factors make it necessary to have
28 more geographic full-time staff. Dalhousie has increased
29 the number from two to twelve in the last five years and
30 will require more. This University has fewer full-time

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1 clinical teachers than most other medical schools.

2 M-49 The major problem in obtaining and retaining
3 clinical teachers is a financial one. To provide salaries
4 from the teaching budget of the University to staff members
5 who also care for the sick in the teaching ward places a
6 heavy load on the University, and in most instances the
7 salaries are not commensurate with what a specialist of simi-
8 lar qualifications and experience could obtain in private
9 practice. Any system of medical insurance for the indigent
10 should permit the payment of the clinical teachers in Uni-
11 versity hospitals on such a basis that their earnings would
12 at least be commensurate with non-teaching specialists in
13 the same fields. At the same time the closed teaching units
14 must be retained as indicated in an earlier section (M-16).

15 Medical Research

16 M-50 Research is a vital activity of a Faculty of
17 Medicine. There are many reasons for this: the vitality
18 of the Faculty is largely measured by the eagerness with
19 which its members pursue knowledge and this vitality is es-
20 sential to good teaching, but today, the prestige of a uni-
21 versity, meaning its standing in the community and among
22 other universities is very largely determined not only by
23 its success in teaching at the undergraduate level but also,
24 perhaps dominantly, by its accomplishments in graduate
25 teaching and research. One has only to think of the great
26 universities of the world to realise that this is so. A
27 university is therefore compelled by the nature of its
28 business and the force of circumstances to provide time,
29 space and facilities and money for graduate training and
30 research. In fact, if it did not do so, it would not be



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3 clinical teachers is a financial one. To provide salaries

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28 business and the force of circumstances to provide time,

29 space and facilities and money for graduate training and

30 research. In fact, if it did not do so, it would not be



1 possible to staff the departments.

2 M-51 The expansion of medical research at Dal-
3 housie has been very striking. One indirect indication is
4 the increase in research grants from the Medical Research
5 Council, Department of National Health & Welfare, Defence
6 Research Board and other agencies. In 1948 there was one
7 small research project receiving a grant of \$3,400. In
8 1954, grants totalled \$80,000. In 1961-1962 research grants
9 already approved exceed \$320,000.

10 M-52 Apart from the Medical Library, no new build-
11 ings have been provided for the Faculty of Medicine since
12 1923 and these had research facilities for only one staff
13 member in each Department. Within the last five years some
14 additional space has been provided for research laboratories
15 through the remodelling of the Medical Science Building
16 and the space vacated by Dentistry in the Forrest Building.
17 In spite of these additions, there is an acute shortage
18 of research facilities. This is now the chief difficulty
19 standing in the way of recruiting staff. Absolutely no
20 facilities for research in the clinical departments were
21 provided within the University until recently when a few
22 rooms in the Public Health Clinic were remodelled. Facilit-
23 ies for research must be provided for the staff and graduate
24 students.

25 M-53 It is now accepted as policy that the full-
26 time staff of each department be adequate to permit approxi-
27 mately fifty percent of the staff time per department to be
28 devoted to medical research during the whole year, i.e.
29 approximately one-third of the time during the academic
30 year together with two summer months, excluding one month
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22 year together with two summer months, excluding one month



1 M-54 In the new Medical Building being planned
2 at Dalhousie for five of the seven pre-clinical sciences it
3 is estimated that the total area required will be 150,000
4 square feet. More than 50 percent of this will be for
5 medical research. In addition, the Dalhousie Public Health
6 Clinic of approximately 25,000 square feet will be remodel-
7 led into research laboratories for the clinical departments.
8 There will, in addition, be need for animal quarters outside
9 these two buildings. The estimated cost of building and
10 furnishing these new research facilities is two and a half
11 million dollars out of the total building cost of four and
12 a half millions.

13 M-55 In 1959 at the request of the Association of
14 Canadian Medical Colleges, the Government of Canada set up
15 a Special Committee to advise on the support of medical re-
16 search in Canada. The two major recommendations of this
17 Committee (1) were that a Medical Research Council be esta-
18 blished and that a fund be set up to aid in the construction
19 of medical research facilities to provide within the next
20 five years twenty-four million dollars for research facili-
21 ties in medical schools and twelve and a half millions for
22 research facilities in teaching hospitals. The first recom-
23 mendation was implemented in part in 1960 when the Medical
24 Research Council was set up under the National Research
25 Council. No action has yet been taken with respect to grants
26 for research facilities.

27 (1) Farquharson, R.F. et al: Report of the Special
28 Committee Appointed to Review Extramural Sup-
29 port of Medical Research by the Government
30 of Canada. November 12th, 1959.

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1 M-56 The National Research Council of Canada pro-
2 vides grants to universities to assist research in chemistry,
3 biology, physics, engineering and other disciplines, and it
4 also operates its own research laboratories in Ottawa and
5 Regional Laboratories in Saskatoon and Halifax. The Medi-
6 cal Research Council provides comparable grants to univer-
7 sities for medical research but has no central research
8 laboratories. The Special Committee recommended to the
9 Government that there should not be central laboratories but
10 in lieu of these there should be decentralised medical re-
11 search facilities of comparable value financed by Govern-
12 ment in the medical schools and their teaching hospitals.
13 This seems to be a reasonable request and does not commit
14 the Government to make a similar outlay for university build-
15 ings in other sciences now provided with such facilities
16 by the N.R.C.

17 M-57 It is recommended that the Royal Commission
18 consider a system of support for the construction of medical
19 research facilities under the Medical Research Council as
20 recommended by the Special Committee on Medical Research.

21 M-58 Medical Science Teaching to Dental Students

22 In the eight functions of the Medical School listed
23 earlier, dental education followed undergraduate medical
24 education and medical research. Most of the information on
25 that programme of dental education is presented by that
26 Faculty. It is sufficient here to mention only that the
27 Faculty of Medicine has always carried out the teaching in
28 anatomy, bacteriology, biochemistry, microanatomy, pathology,
29 pharmacology and physiology for dental students as well as
30 medicals. Most of the teaching is done in combined classes.

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pharmacology and physiology for dental students as well as

medicals. Most of the teaching is done in combined classes.



1 The new Dental Building was planned to accommodate twenty-
2 five to thirty students in the clinical departments, in-
3 stead of the former ten or twelve. The proposed new Medi-
4 cal Building is being planned with a view to the needs of
5 Dentistry as well as Medicine. Unless this building can be
6 provided soon, it may be impossible to take in all of the
7 available students from the Atlantic Region who wish to
8 study medicine or dentistry, but every effort will be made
9 to prevent such a limitation on enrolment in either Faculty.

10 Undergraduate and Graduate Education in the
11 Medical Sciences

12 M-59 The teachers in the Medical Science Depart-
13 ments of Dalhousie Medical School are highly qualified in
14 fields of science, which in most instances are not other-
15 wise represented in the University. The Faculty of Medicine
16 is prepared to share the skills of these medical scientists
17 with the Faculties of Arts & Science and of Graduate Studies,
18 and in turn the Faculty of Medicine gains by having graduate
19 students participate in their research projects. However,
20 it is not sufficient merely to set up M.Sc., and Ph.D.pro-
21 grammes in biochemistry, physiology, bacteriology, pharma-
22 cology, etc. In order to recruit graduate students into
23 these Departments, it is necessary to acquaint the under-
24 graduate students with the scope and problems of these
25 disciplines. Courses for junior and senior students must
26 therefore be provided under the aegis of the Faculty of
27 Arts & Science, in such fields and under such teachers of
28 the Medical Faculty as are approved the Faculty of Arts
29 & Science.

30 M-60 It is the policy of the Faculty of Medicine



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provided soon, it may be impossible to take in all of the

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1 that these science courses be strictly limited in regist-
2 ration. Under ordinary circumstances a department of the
3 Medical School will not undertake more than two such courses,
4 each with an enrolment not exceeding twenty. This is meant
5 to prevent the Medical Science Departments of the Medical
6 School from becoming overloaded with students of other
7 faculties.

8 M-61 There are practically no facilities in the
9 Medical School for these graduates and undergraduate stu-
10 dents in science. As already indicated, the buildings were
11 constructed for medical and dental teaching only, with a very
12 small allocation of research space for one professor in
13 each department. The graduate students are at present
14 fitted into whatever space can be found. Some of the al-
15 ready inadequate teaching laboratories have been given over
16 to graduate students and to research laboratories for staff
17 members. There are no small lecture rooms, no seminar
18 rooms, no science laboratories in any department, other than
19 those designed for medical and dental students. The teach-
20 ing programme for medical and dental students is so heavy
21 that no time can be scheduled to fit science classes into
22 their laboratories except in the new addition to the Path-
23 ology Institute which will provide space for science stu-
24 dents in the two Departments located in that building.

25 M-62 In the proposed new Medical Building pro-
26 vision will be made for two classes of twenty undergraduates
27 science students in each basic science department of the
28 Medical School and research space for two graduate students
29 per full-time staff member in each Medical Science Depart-
30 ment. The total enrolment of graduate students in the

and other staff are appointed, to a maximum of sixty or seventy.

Post-graduate and General Medical Education

M-63 It has been estimated that research is doing
ling our kind of scientific information every ten years,
and that the past fifty years have seen more advances in
medicine than the whole preceding period in history. While
the necessity for continuing one's medical education through
out a life-time of practice has been reiterated since Hippo-
cratic days, the speed of recent developments make life-
long medical training for today's practicing doctor a mat-
ter of vital concern because of the effects of his services
on the public welfare.
M-64 It is a new idea to most universities that

they should accept any responsibility for helping keep
their graduates educated for the rest of their lives. Many
educators say that this is the individual's own responsibility
after he has received the university's stamp of approval.
In the slower paced era of only a few decades ago
this philosophy worked reasonably well. Certainly it is
still the primary aim of Dalhousie Medical School to in-
cubate habits of study which will help a graduate keep
up-to-date in his field. However, it is impossible to make
a student reasonably proficient in all phases of medicine
increase in knowledge, makes it essential that some graduates
take specialty training in a limited field, and that those



Departments of Anatomy, Microanatomy, Physiology, Biochemistry and Pharmacology on this basis might reach thirty by 1965 and might increase, as more Medical Research Associates and other staff are appointed, to a maximum of sixty or seventy.

Post-Graduate and Continuing Medical Education

M-63 It has been estimated that research is doubling our fund of scientific information every ten years, and that the past fifty years have seen more advances in medicine than the whole preceding period in history. While the necessity for continuing one's medical education throughout a life-time of practice has been reiterated since Hippocratic days, the speed of recent developments make lifelong medical training for today's practising doctor a matter of vital concern because of the effects of his services on the public welfare.

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1 who go into general practice receive post-graduate train-
2 ing at frequent intervals. Dalhousie University has accept-
3 ed responsibility in both of these fields, the training of
4 specialists and the continuing medical education of practi-
5 tioners. In fact, Dalhousie has participated in this latter
6 field for more than thirty-five years through the annual
7 Dalhousie Refresher Course. The Division of Post-Graduate
8 Medical Education has been set up in the Faculty to organise
9 and supervise these programmes.

10 M-65 Over one-third of the medical graduates of
11 Dalhousie go on to take a four-year graduate course in a
12 clinical specialty, leading to certification of fellowship
13 in the Royal College of Physicians and Surgeons of Canada.
14 There are approximately sixty such residents in University-
15 affiliated hospitals in Halifax. With the proposed enlarge-
16 ment of these hospitals in the near future, the number of
17 such specialists-in-training will probably double. Their
18 training is officially the responsibility of the hospital,
19 but all clinical teachers in these hospitals are members
20 also of the Faculty of Medicine. The same people are
21 therefore required to shoulder the load of post-graduate
22 as well as undergraduate education. Again it is
23 emphasised that the number of full-time clinical teachers
24 is very small and most of the teaching is done by practis-
25 ing specialists. Post-graduate students also require
26 advanced teaching in the application of the medical sciences
27 to clinical medicine, and this is the responsibility of the
28 Medical Science Departments. This large number of specialits-
29 in-training in the affiliated hospitals therefore adds
30 greatly to the responsibility of the Clinical Departments

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1 of the Medical School, and to a lesser degree to the
2 Medical Science Departments.

3 Facilities will be provided in the new Medical Building
4 for post-graduate students in the clinical specialties
5 as well as graduate students in the medical sciences.
6 There is a great dearth of medically qualified teachers
7 in the basic science departments, partly due to the fact
8 that most Canadian medical schools have not provided
9 facilities for these residents.

10 Special mention should be made of the training of
11 specialists in psychiatry at Dalhousie. Because of the
12 great shortage of specialists in this field, the Univer-
13 sity requested in 1948 that the Federal Provincial Mental
14 Health Grant be used in part to support a training
15 programme for psychiatrists and clinical psychologists.
16 The four Atlantic Provinces have supported this since 1949.
17 Full-time and part-time teachers were appointed to carry
18 out both graduate and undergraduate teaching. The
19 current budget for the graduate programme exceeds \$30,000
20 per annum. Most of the graduate students are also
21 supported by bursaries of approximately \$3,000 per year,
22 often supplemented by a partial salary from the Department
23 of Health of the province to which he is committed to
24 return. This system of support for both the institution
25 providing the training and the graduate student himself
26 has much to commend it, as a means of reducing the
27 shortage of specialists in certain fields.

28 The programme of the Dalhousie Division of Post-
29 Graduate Medical Education is provided by a Director and
30 Secretary with the part-time assistance of one hundred and

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supported by bursaries of approximately \$3,000 per year, often supplemented by a partial salary from the Department of Health of the province to which he is committed to return. This system of support for both the institution

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1 twenty-six faculty members, sixty guest lecturers from the
2 Atlantic Provinces, and twenty-seven guest Faculty members
3 from medical schools outside the Atlantic Provinces. A
4 small residency training programme in the pre-clinical
5 sciences presented sixty hours of lectures to a registration
6 of forty-nine specialists in training in Halifax as intra-
7 mural activity, and sixty-four hours of clinical instruction
8 to a registration of fifty doctors in an extra-mural pro-
9 gramme in Saint John, New Brunswick. These programmes
10 together with the training of psychiatrists described above,
11 and close collaboration in the clinical training of all
12 residents in the affiliated hospitals represent the Univer-
13 sity's contribution to the education of specialists.

14 M-69 The major effort of the Division is devoted
15 to the provision of continuation medical education for the
16 family doctor. The 1960-1961 programme in Halifax featured
17 146 presentations with an attendance of 4,277 doctors. The
18 extra-mural programme consisted of 216 presentations to an
19 attendance of 6,140 doctors in communities spread over the
20 four Atlantic Provinces. This is by far the largest pro-
21 gramme of continuing medical education in Canada and repres-
22 ents a tremendous contribution by Dalhousie to the health
23 programmes of the whole Atlantic Region. Nevertheless, it
24 is believed that the continuing medical education of the
25 Division needs to be expanded further. This programme
26 provides just over nine hours per registered practitioner
27 of medicine per year in the form of formal educational op-
28 portunities, to supplement his professional reading, much
29 less than is recommended as ideal.

30 M-70 The College of General Practice of Canada



Atlantic Provinces, and twenty-seven Great Faculty members

from medical schools outside the Atlantic Provinces. A

small residency training programme in the pre-clinical

sciences presented sixty hours of lectures to a registration

of forty-nine specialists in training in Halifax as interns

rural activity, and sixty-four hours of clinical instruction

to a registration of fifty doctors in an extra-rural pro-

gramme in Saint John, New Brunswick. These programmes

together with the training of psychiatrists described above,

and close collaboration in the clinical training of all

residents in the affiliated hospitals represent the Univer-

sity's contribution to the education of specialists.

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requires for maintenance of membership, attendance of fifty hours formal continuation medical education every two years. While it is not considered essential or even desirable that all of this continuation medical education should be obtained by every practitioner in the four Atlantic Provinces from this one Medical Faculty, it is reasonable to assume that most of it would be accepted if available near at hand. It is also recognised that this requirement is only 50 percent of that recommended by practising doctors (1) themselves. It would seem reasonable to aim for forty hours a year for all doctors in our area. This would require considerable expansion of teaching staff and funds to bring visiting teachers, as well as an increase in administrative staff of similar proportion, and the development of teaching facilities (primarily teaching beds) for intra-mural teaching in Halifax, and extra-mural teaching in strategically located community hospitals throughout the four Provinces.

M-71 The extensive programme of continuing medical education in the Atlantic Region and residency training in the affiliated hospitals has in very large part been carried without remuneration by the part-time clinical teachers, and has placed an increased load on the relatively few full-time teachers. To increase it further will require a very considerable enlargement of staff and an increase in the financial expenditures of the University. Bursaries for post-graduate students, as now available in psychiatry, are also needed.

(1) Vallan, D.D.: Postgraduate Medical Education in the United States. A.M.A. Publication, 1955. p. 28-29.

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1 M-72 Since Dalhousie is the only Medical School
2 in the four Atlantic Provinces, it is natural that the
3 medical profession, Governments and the public look to this
4 University for the education of other health personnel as
5 well as doctors and dentists. This has already been il-
6 lustrated by the establishment of courses in graduate nur-
7 sing, psychiatry and clinical psychology supported by the
8 Departments of Public Health of the four Atlantic Provinces.
9 A few years ago one interested group of the medical profes-
10 sion also suggested the establishment of a School of Physio-
11 therapy and Occupational Therapy. This was recommended by
12 the Faculty of Medicine and has been approved by the Board
13 of Governors subject to space and financial requirements
14 being met. The reorganisation of the College of Pharmacy
15 in 1961 within the University also required an increase in
16 teaching within the Departments of the Medical School. The
17 need for more University graduates in the fields of medical
18 biochemistry, pathology, bacteriology, etc. has recently
19 been emphasised by the Consultant in Laboratory Services of
20 the Nova Scotia Hospital Insurance Commission. He has re-
21 quested assistance from Dalhousie University in organising
22 such courses to the B.Sc. and M.Sc. level. The Faculty of
23 Dentistry has established a course in dental hygiene, which
24 will also add to the teaching in the Medical Science Depart-
25 ments of the Medical School.

26 M-73 It is a conservative estimate that within
27 five years there will be over 125 students per year re-
28 quiring at least one course in the several departments of
29 medical science, and the total enrolment of such students
30 may reach nearly 300.

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1 M-74 There is no doubt concerning the need for
2 trained personnel on all of these fields. However, there
3 may be a difference of opinion as to whether some of the
4 requirements should be met by vocational schools rather
5 than universities. The trend in most parts of North America
6 is to have these needs met by universities, and Dalhousie
7 has to follow the trend unless, as seems unlikely, the needs
8 are met by vocational or technical schools.

9 M-75 It is planned that staff and facilities be
10 provided for one basic course designed for students in the
11 Health Professions in each Medical Science Department of the
12 Medical School. It is not intended that separate courses
13 be given for each of these para-medical disciplines, but
14 only one basic course, which can be expanded or adapted by
15 the teachers of the specialty itself. Facilities for the
16 medical science classes for these health professions will
17 be provided in the proposed new Medical Building, but their
18 professional training will have to be conducted in other
19 quarters. It is considered likely that the present Medi-
20 cal Sciences Building or a part of the Forrest Building
21 would be suitable, when these are vacated by the Medical
22 Science Departments.

23 M-76 The University has established a Faculty of
24 Health Professions under which the Schools of Nursing and
25 Pharmacy are now operating and which will also include the
26 School of Physiotherapy and Occupational Therapy. Another
27 section of the brief deals with that Faculty.

28 M-77 Recommendation It is recommended that, in
29 addition to scholarships for students, the Government of
30 Canada should support medical education at Dalhousie by

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Recommendation It is recommended that, in addition to scholarships for students, the Government of Canada should support medical education at Dalhousie by



1 annual grants based on student enrolment. It is recommended
2 that this grant be at least \$1000 per student, increasing
3 to \$2000 over a five-year period. This would provide an
4 additional \$273,000 to Dalhousie Medical School, based on
5 present enrolment. Approximately \$23,000 would be required
6 to cover the present operating deficit, leaving \$250,000
7 for expansion. This would allow, first, some very necessary
8 improvements in the present salary structure and honaria
9 for part-time clinical teachers. An increased honorarium
10 of \$500 to the part-time clinicians would in itself require
11 more than \$60,000 per year. Modest salary increases of
12 the forty-one full-time staff would add another \$40,000.
13 The addition of two full-time staff members in each of the
14 six major clinical departments would require almost \$150,000.
15 In fact, twelve additional full-time members will not be
16 sufficient to take care of the post-graduate programmes for
17 residents, the continuing medical education of practitioners
18 and other rapidly growing programmes. Increased enrolment
19 when the new Medical Building is completed will require more
20 staff in the basic science departments. It is therefore ex-
21 pected that within five years the grant would have to reach
22 \$2000 per student. This sum will certainly be required if
23 the staff is increased to permit lengthening of the
24 academic year.

annual grants based on student enrollment. It is recommended that this grant be at least \$1000 per student, increasing to \$2000 over a five-year period. This would provide an additional \$275,000 to Delaware Medical School, based on present enrollment. Approximately \$23,000 would be required for part-time clinical teachers. An increased honorarium of \$500 to the part-time clinicians would in itself require more than \$60,000 per year. Modest salary increases of \$1000 for each of the staff members in each of the six major clinical departments would require almost \$150,000. In fact, twelve additional full-time members will not be sufficient to take care of the post-graduate programs for and other rapidly growing programs. Increased enrollment when the new Medical Building is completed will require more staff in the basic science departments. It is therefore expected that within five years the grant would have to reach \$2000 per student. This sum will certainly be required if the staff is increased to permit lengthening of the academic year.



FACULTY OF DENTISTRY

D1 Introduction

It should be stated at the outset that this section of the Brief is essentially a subjective report. Statistical information and staff are not available to provide the graphic evidence to substantiate many of the comments, but the statements made are based upon observations, experience, and the best information available to us.

D2 Function

From the time of its establishment, the Faculty of Dentistry has served the Atlantic areas of Canada. Its two chief functions are to provide educational opportunities for young people of the region who wish to pursue careers in Dentistry, and to provide dental personnel for the area. A responsibility to provide continuing education for members of the dental profession, and to support dental research is also recognised. To the best of its extremely limited ability to do so, the University affords such opportunities.

D3 Education Programme

Pattern: Dental education at Dalhousie follows the traditional pattern which has been developed on the North American Continent, and every effort is made, indeed must be made, to meet at least the minimal standards for approval by assessment groups of the profession. Without such approval, licensing agencies would refuse to recognise graduates of the school, because the best interest of the public would not be served. In addition, the already difficult task of recruiting competent staff would become impossible.

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become impossible.



1 D4 As with the other Canadian schools, the
2 Faculty has been surveyed on several occasions since 1950
3 by a committee of the Council on Education of the Canadian
4 Dental Association. The standards here meet with their
5 approval. Graduates fulfill the academic requirements for
6 admission to licensure examinations in each of the ten
7 provinces, and the National Dental Examining Boards in
8 Canada and the United States. Since 1957, the Provincial
9 Dental Board of Nova Scotia has accepted the graduates of
10 this University for licensure, without further examination.

11 D5 Course: The course of studies extends over
12 a period of six years, following matriculation into Dal-
13 housie University, which in the Province of Nova Scotia is,
14 at present, Grade XI. In effect, there are three broad
15 phases to the programme, as follows:

16 D6 (1) Two years of pre-professional study in
17 a faculty of arts and science, which may be taken at any
18 university recognized by Dalhousie. This period serves to
19 provide the students with the basic knowledge required for
20 succeeding scientific courses, to broaden their knowledge
21 through liberal arts courses, and to permit a greater de-
22 gree of maturity. In addition, a major portion of the
23 selective screening of students is accomplished before ad-
24 mission to the dental faculty at less cost to the student
25 and to the University, and at a time when the student may
26 turn to other areas of study with relative ease, should that
27 be desirable.

28 D7 On the satisfactory completion of ten uni-
29 veristy classes, of which eight are specified, the student
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(2) Two years of study in the basic medical

and dental sciences, and introductory clinical courses.

In the main, the medical science classes are offered by Departments of the Faculty of Medicine, and the medical and dental students form one class. In most respects this is a very happy arrangement. Under this system, students of dentistry derive benefit from association with medical students who will be their confreres in the future, and with whom, on occasion, they must work in close cooperation.

The converse is also true. Undoubtedly, better instruction is provided, at less cost, than if separate departments were to be set up within each school. The larger departments tend to attract better qualified teachers who feel keenly the necessity for close associates with whom they can readily exchange ideas, particularly on research.

D9 On the other hand, the gap between the basic science subjects and clinical dentistry tends to be broader when the dental faculty does not operate its own basic science departments. The medical scientist is primarily interested in problems directly associated with medicine and the applications to dentistry are of secondary importance to him. This orientation has a more profound influence on dentistry than might seem evident at first glance. Dental research and dental prevention will be advanced chiefly as knowledge in the basic sciences is developed, and students must receive a thorough basic understanding of these subjects if they are to adapt themselves to changes in the future. There is little doubt that better integration of the basic and clinical sciences would result if the Faculty of Dentistry had its own

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departments in the basic medical sciences. The teachers' interests would be oriented more closely to dentistry. Not only the teaching would be strengthened by this change, but more students would be motivated to pursue careers in the basic sciences, and more opportunity would be available to them on graduation. Separate medical science departments should be established within the Dental Faculty at such time as the increased student enrolment warrants separate classes from the medical students.

D10 (3) The final two years of the undergraduate programme are devoted largely to practical experience in the clinic operated by the Faculty and in affiliated hospitals, together with lectures and seminars.

D11 Academic Year: For the first two years in the Faculty, the course extends over a period of approximately thirty-three weeks plus examinations, and in the third and fourth years for approximately thirty weeks plus examinations. Within two years, or as soon as the number of students in the clinical years has increased appreciably, it will be necessary to increase the length of the third year course by approximately four weeks, because of the arrangement of our physical facilities.

D12 Continuing pressures from Faculty members, the dental profession, and others, for additional teaching time in many subjects, and for new courses, creates problems of programme planning which could be solved more easily by an additional teaching year. Within the past eight years the length of the academic year for this Faculty has increased by four to six weeks, and consideration may have to be given to a further extension, but at this

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1 time it does not seem reasonable to increase the number of
2 years.

3 D13 Development: The programme of dental educa-
4 tion is under going continuing improvement and review.-
5 Dramatic changes have taken place in this Faculty since
6 the Second World War, through the efforts of the University
7 itself, the Council on Education of the Canadian Dental
8 Association, and the financial support of the W.K. Kellogg
9 Foundation. Improved physical facilities, additional full-
10 time teaching staff, and training programmes for the teach-
11 ers both within the University and at the post-graduate
12 and graduate level at other institutions, have enabled the
13 Faculty to increase the effectiveness of its teaching.

14 D14 Objectives: In February of 1961 the Faculty
15 reviewed the objectives of its programme and approved the
16 following statements:

17 D15 1. "As a small School, activity must be
18 restricted chiefly to undergraduate instruction designed
19 to provide a more adequate supply of well-qualified Den-
20 tists for the Atlantic Provinces.

21 D16 2. "Although for the immediate future Gra-
22 duate instruction must be left to larger and more generous-
23 ly financed Schools, this Faculty must provide frequent
24 and varied opportunities for continuing education in Den-
25 tistry at the post-graduate and refresher-course levels,
26 so that the practitioners of the region may be assisted in
27 improving and advancing their services.

28 D17 3. "It is axiomatic that university grad-
29 uates should be educated men and women capable of critical,
30 original and objective thinking. The programme of the

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1 Faculty should be designed, therefore, to produce profes-
2 sional people willing and able to assume positions of
3 responsibility and leadership in their respective communi-
4 ties.

5 D18 4. "All courses should be designed to stimu-
6 late and motivate the students to strive towards the ideals
7 of the profession of Dentistry.

8 D19 5. "The detailed course of instruction should
9 assist the student to acquire a fundamental knowledge and
10 understanding of the sciences basic to clinical practice,
11 and enable the student to adapt himself to developments and
12 changes of the future.

13 D20 6. "Because it is not possible to provide
14 sufficient experience for students to develop a high degree
15 of proficiency in all phases of Dentistry within a reason-
16 able time limit for an undergraduate programme, instruc-
17 tion in the technical phases of laboratory and clinical
18 Dentistry must be restricted severely, at the same time,
19 ensuring an adequate level of competence in the basic
20 areas.

21 D21 7. "The undergraduate programme must include
22 direction and guidance to the student about his personal
23 and professional relations with the public, his colleagues,
24 auxiliaries, and members of the allied professions, in
25 order that he may learn to work effectively with each.

26 D22 8. "In order to further this objective in-
27 sofar as it applies to auxiliaries, the Faculty should
28 undertake the training of Hygienists as soon as is prac-
29 tical. The Faculty should explore the extent to which
30 additional duties may be delegated to adequately trained

personal people willing and able to assume positions of responsibility and leadership in their respective communities.

4. "All courses should be designed to stimulate and motivate the students to strive towards the ideals of the profession of Dentistry.

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8. "In order to further this objective insofar as it applies to auxiliaries, the Faculty should undertake the training of Hygienists as soon as it is practical. The Faculty should explore the extent to which additional duties may be delegated to adequately trained



auxiliaries. It should also cooperate with the profession in the establishment of training programmes for dental auxiliaries.

D23 9. "An appreciation of, and interest in Research must be fostered. To this end an opportunity must be provided for students to be made aware of Research activity by direct contact with those conducting projects, and also by affording the opportunity for interested students to do Research work."

D24 Continuing Dental Education: Despite the need for additional practising specialists in the region, the Faculty is unable, at present, to offer instruction in either specialty or graduate dental education. To do so would require unforeseen assistance from the basic science departments, additional specialists on the clinical teaching staff, and additional physical facilities. Advanced education is limited, therefore, to refresher and short post-graduate courses. These have been undertaken on a regular basis within the past three years. Courses in various clinical subjects are offered three to four times a year, to the general practitioners of the Atlantic Provinces. Depending on the subject, and the facilities for the programme, each class has a limit of six to twelve. In most instances, guest clinicians have been obtained from our sister universities in Canada and the United States. The response, while not overwhelming, has been gratifying. It would appear to be a useful and appreciated service.

D25 Research

Dental research is extremely limited at Dalhousie by physical facilities, finances, staff, and

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1 available staff time. It is difficult to say in which
2 area the need is most acute.

3 D26 Within the past ten years, dental research
4 projects may have been undertaken by the Departments of
5 Anatomy and Pharmacology, supported by grants from the
6 Associate Committee on Dental Research of the National Re-
7 search Council of Canada and the Council on Education of the
8 Canadian Dental Association. In the same period, two pro-
9 jects have been undertaken by members of the dental staff,
10 and six students have been supported by Student-ships for
11 summer research activities. There has been no money for
12 research in the budget of the Faculty. It had to be se-
13 cured from agencies outside the University.

14 D27 It may not be necessary for all good teachers
15 to engage in research, but it is well recognized by dental
16 educators that research activity is vital to a good Faculty.
17 Without active programmes, students will not be made fully
18 aware of the true value of research and its implications,
19 nor will there be the stimulus necessary to create additio-
20 nal and sorely needed workers in the field.

21 D28 There is an urgent need for more dental
22 research work and its support in this Faculty.

23 D29 Staff

24 Number: Until 1953, there was only one full-
25 time teacher in the Faculty. Except for classes in the
26 basic medical sciences, instruction was given almost enti-
27 rely by the practitioners of Halifax and Dartmouth, who
28 devoted from one to four hours a week to teaching. In
29 addition to those in the basic medical science departments,
30 there are now five full-time teachers, including the Dean,
seven teachers serving two to three half-days a week, and

available staff time. It is difficult to say in which areas the need is most acute.

Within the past ten years, dental research projects may have been undertaken by the Departments of Anatomy and Pharmacology, supported by grants from the Associate Committee on Dental Research of the National Research Council.

Canadian Dental Association. In the same period, two projects have been undertaken by members of the dental staff, and six students have been supported by student-ships for summer research activities. There has been no money for research in the budget of the Faculty. It had to be secured from agencies outside the University.

It may not be necessary for all good research to engage in research, but it is well recognized by dental educators that research activity is vital to a good Faculty. Without active programmes, students will not be made fully aware of the true value of research and its implications, nor will there be the stimulus necessary to create additional and sorely needed workers in the field.

There is an urgent need for more dental research work and its support in this Faculty.

Staff

Number: Until 1953, there was only one full-time teacher in the Faculty. Except for classes in the basic medical sciences, instruction was given almost entirely by the practitioners of Halifax and Dartmouth, who devoted from one to four hours a week to teaching. In addition to those in the basic medical science departments there are now five full-time teachers, including the Dean.



1 nineteen serving for a half a day or less. There is also
2 one new member of the full-time teaching staff on leave of
3 absence to pursue graduate studies, and there is provision
4 in the current budget for one more full-time teacher.

5 D30 Requirements: One of the difficulties in a
6 small school is to obtain a reasonable balance between the
7 cost of the programme and the appointment of a sufficient
8 number of full-time teachers for the various areas in which
9 their services are essential. Previous reference was made
10 to the necessity for research and to the desirability of
11 separate basic science departments. Each involves more
12 staff. The need for additional full-time teachers is also
13 made more acute by the scarcity of practising specialists
14 in the community who might be available for part-time
15 teaching duties.

16 D31 Based on the projected size of class for the
17 present building, at least five additional full-time
18 teachers could be used effectively and efficiently in the
19 clinical programme if financial support, office and labora-
20 tory accommodation could be provided for them.

21 D32 Recruitment: Despite the fact that the
22 salaries offered by Dalhousie bear a reasonable relation-
23 ship to those in the other Canadian dental schools, great
24 difficulty has been experienced in the recruitment of com-
25 petent full-time teachers. In the majority of such appoint-
26 ments, this University has found it necessary to subsidize
27 prospective staff members through a period of specialized
28 education in order to entice them from the attractions of
29 private practice. This is not too surprising, however,
30 when one considers the existing incongruous situation in

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Recruitment: Despite the fact that the

salaries offered by Dalhousie bear a reasonable relation-

to those in the other hospitals in the area,

difficulty has been experienced in the recruitment of competent full-time teachers. In the majority of such appointments, this University has found it necessary to subsidize

prospective staff members through a period of specialized education in order to entice them from the attractions of private practice. This is not too surprising, however,

when one considers the existing incongruous situation in



1 which the salaries offered to teachers, who should be
2 among the more outstanding people in their particular
3 fields, are less than the income of a reasonably competent
4 general practitioner. The difficulties have been accentua-
5 ted by the dramatically increased demand for full-time
6 teachers by all of the dental schools, and dental teachers
7 must be attracted from an educational programme which,
8 until recently, was directed solely to training for private
9 practice.

10 D33 The salaries must be increased, and other
11 incentives offered to ensure an adequate number of teachers
12 to meet future requirements.

13 D34 Part-time Staff: The practising dentist
14 continues to be a vital and very essential member of the
15 teaching staff, making his most significant contribution
16 from experience with the practical problems encountered in
17 private practice. His effectiveness would be greatly in-
18 creased, out of proportion to the time involved, if he were
19 able to offer a minimum of four or five half days a week
20 to teaching. To date, however, this University has not
21 been in a position to offer a reasonable remuneration to
22 include the heavy on-going expense of maintaining his of-
23 fice while absent from it to assume teaching duties. To
24 their great credit, members of the profession have been
25 willing to make financial sacrifice for one or two half
26 days a week in order to serve their profession at the Uni-
27 versity, but one cannot expect unlimited sacrifices.

28 D35 Non-academic Staff: Additions to the teach-
29 ing staff would require automatic increases to the technical
30 and secretarial staff, which to date the University has been

which the salaries offered to teachers, who should be among the more outstanding people in their particular fields, are less than the income of a reasonably competent general practitioner. The difficulties have been accentuated by the dramatically increased demand for full-time teachers by all of the dental schools, and dental teachers must be attracted from an educational programme which, until recently, was directed solely to training for private

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D35 Non-academic Staff: Additions to the teaching staff would require automatic increases to the technical and secretarial staff, which to date the University has been



1 able to maintain at a reasonable level.

2 D36 It is believed that the teaching programme
3 could be more efficient and more effective if auxiliary
4 personnel could be employed in increasing numbers. The
5 dental assistant, dental hygienist, and dental technician
6 could be used to assist the student in many additional clinical
7 duties, thus relieving him of non-essential tasks
8 which he now must undertake personally. At the same time,
9 the student would be trained to use auxiliaries more
10 effectively in his subsequent practice. At present, neither
11 the trained personnel nor finances are available in sufficient
12 quantity for this purpose.

13 D37 Physical Facilities

14 From the time of its establishment until
15 1958, the clinical facilities for the Faculty were located
16 in the Forrest Building, which initially accommodated
17 the entire University. In 1953, the Board of Governors
18 decided that the Faculty required greatly improved physical
19 facilities which could be provided only in a new building.
20 Because of the high and increasing population per dentist
21 in the area, it was also decided that the new quarters
22 should enable the student enrolment to be doubled.

23 D38 Present accommodation: Accordingly, plans
24 for the new building were made with the understanding that
25 the cost must be kept to an absolute minimum, consistent
26 with the provision of a building which would permit a high
27 standard of dental education. It was to accommodate twenty-
28 five students in each class, and classes of approximately
29 nine students in each of the two years of a course for
30 dental hygienists. Other classes are offered in the basic

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Physical Facilities

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decided to build a new building for the Faculty of Dentistry.

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five students in each class, and classes of approximately

nine students in each of the two years of a course for

dental hygienists. Other classes are offered in the basic



1 science departments of the Faculty of Medicine, and in
2 affiliated teaching hospitals (see Faculty of Medicine re-
3 port).

4 D39 Limitations: The physical facilities for
5 the Faculty are of excellent quality, although fairly re-
6 stricted in size. The number of operating units in the
7 clinic is significantly smaller in proportion to the number
8 of dental students, than those in the other Canadian schools.
9 This economy was achieved by a plan to assign a junior and
10 a senior student to the same working area for alternating
11 periods. A slight increase in the length of the academic
12 term for the third year students will be necessary to con-
13 tinue to provide the same amount of clinical experience.
14 Accommodation for specialized clinics was kept to a bare
15 minimum. There is no special provision for post-graduate
16 and refresher courses, which imposes a limitation on the
17 type of course and the number of students to be accommodated.

18 D40 The greatest space limitations, however, are
19 in office and laboratory accommodation for the teaching
20 staff. When the present teaching establishment has been
21 filled, no further office space will be available in the
22 present building.

23 D41 Laboratory space for research is limited to
24 an area of approximately 789 square feet in two rooms which
25 must also be used for laboratory preparation and teaching.

26 D42 Without additions to the building, it would
27 not be possible to increase the class enrolment beyond
28 twenty-five dental students and approximately fourteen
29 dental hygienists.

30 D43 Reference is made, in the section of the

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science departments of the Faculty of Medicine, and in



report dealing with the Faculty of Medicine, to the accommodation for the basic medical science classes for dentistry.

D44 The Library for the Dental Faculty is now situated in the Medical-Dental Library Building, which was designed in 1939 to accommodate classes of approximately twelve dental and fifty to sixty medical students. Apart from the fact that the building is no longer conveniently located so that it can be used most effectively by the dentistry students, accommodation is overtaxed and provision of additional space is essential. Any future expansion of the Dentistry Building should make provision for the location of the dental library within the Faculty Building.

D45 The Victoria General Hospital and the Children's Hospital have teaching affiliations with the University, and may be used for the educational programme in dentistry. Their physical facilities for dentistry in both institutions are at a minimal level, and substantial improvement is necessary if they are to be used as effective teaching units. Problems of dentistry for the physically handicapped, for those requiring hospitalization for medical or surgical reasons, and the increasing number of geriatric patients make hospital training an essential part of the undergraduate dental curriculum.

D46 Students

Until the establishment of the Faculty, the nearest educational centres for the study of dentistry were in Montreal and Boston. Dalhousie has the only Faculty of Dentistry in the Atlantic Provinces. Service to the



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Students

Until the establishment of the Faculty, the
nearest educational centres for the study of dentistry were
located in the Atlantic Provinces. Service to the



region can be seen from the following table which shows that an increasing number, and now the majority, of dental students from the Atlantic community receive their professional education at Dalhousie University:

Origin of Dental Students

Five-Year Period: 1951-52 -- 1955-56

	<u>Nfld.</u>	<u>N.B.</u>	<u>N.S.</u>	<u>P.E.I.</u>
Total No. Canadian Dental Students	56	101	140	39
Total No. at Dalhousie University	38	47	129	15
% of Total Canadian Students at Dal.				
	67.8	46.5	94.8	38.4
% of Total Canadian English-speaking Students at Dalhousie	67.8	61.8	94.8	41.6

Five-Year Period: 1956-57 -- 1960-61

Total No. Canadian Dental Students	51	98	93	16
Total No. at Dalhousie University	42	60	88	10
% of Total Canadian Students at Dal.				
	82.3	61.2	94.6	62.5
% of Total Canadian English-speaking students at Dalhousie	82.3	86.9	95.6	83.3

Ten-Year Period: 1951-52 -- 1960-61

Total No. Canadian Dental Students	107	199	233	55
Total No. at Dalhousie University	80	107	217	25
% of Total Canadian Students at Dal.				
	74.7	53.7	93.1	45.4
% of Total Canadian English-speaking students at Dalhousie	74.7	71.8	95.1	50.4

D47 Enrolment: The following Table shows the total student enrolment in the Faculty of Dentistry at Dalhousie University from 1929-30 until the current session, 1961-62:



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Five-Year Period: 1951-52 -- 1955-56



Year	Student Enrol- ment	Year	Student Enrol- ment	Year	Student Enrol- ment
1929-30	30	1940-41	31	1951-52	49
30-31	27	41-42	25	52-53	50
31-32	21	42-43	39*	53-54	50
32-33	21	43-44	22	54-55	48
33-34	33	44-45	20	55-56	47
34-35	39	45-46	27	56-57	47
35-36	54	46-47	37	57-58	53
36-37	51	47-48	37	58-59	55
37-38	47	48-49	41	59-60	59
38-39	37	49-50	48	60-61	53
39-40	35	50-51	48	61-62	60

* Special accelerated classes during War Years.

D48 Until provision of the present building, total enrolment was limited by facilities and staff to approximately fifty students. Although the building was first occupied in 1958, the class size could not be increased until necessary additions had been made to the full-time teaching staff. It was not until 1960-61 that the Faculty was prepared to accept a full complement of twenty-five freshmen students. The actual enrolment of freshmen in that year was fifteen. For the current year the number has been increased slightly. There are eighteen in the freshmen class, including seven students from outside the Atlantic community.

D49 Applicants: With such small classes, an accurate analysis of the year to year changes in the quality of applicants cannot be made. It is our opinion, however, that there has been no significant change in quality,



1 within the past eight years, unless it is a slight im-
2 provement.

3 D50 For the past several years, all qualified
4 students from the four Atlantic Provinces who sought ad-
5 mission have gained acceptance.

6 D51 Recruitment: This indicates the very real
7 necessity of recruiting students for the profession of den-
8 tistry. The pressure of teaching duties and other admini-
9 strative matters have been so great upon the staff that they
10 have been unable to devote more than a token amount of time
11 to this task. When requested, Faculty members have been
12 only too willing to attend career programmes in the high
13 schools of the Province, and efforts have been made to en-
14 courage students who show an interest in the profession, by
15 inviting them to visit the school.

16 D52 While the University accepts its share of
17 responsibility for recruitment, members of the profession,
18 individually and collectively, must share the greater bur-
19 den of responsibility. It is gratifying to note that the
20 Canadian Dental Association and the individual Associations
21 in this region have taken steps to organize recruitment
22 committees at the national, provincial, and local levels,
23 but some years will elapse before the full effect of even
24 the most energetic recruitment programme can be realized.

25 D53 An increase in the number of applicants may
26 be anticipated in succeeding years, because registration
27 in the liberal arts colleges has begun to reflect the popu-
28 lation 'explosion' of the 1940's, and these students are
29 just now attaining age to seek admission to the dental
30 schools. It is doubtful, however, whether this development

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1 alone will result in the required number of candidates
2 for dentistry. Studies elsewhere indicate that the most
3 effective recruitment is done by the individual dental
4 practitioner. The very scarcity of dentists may be re-
5 flected in an inadequate supply of prospective students,
6 and thus, greater effort must be made by each individual
7 to be an active 'ambassador' for the profession.

8 D54 The Faculty is not aware of any Canadian
9 study on the origin of dental students, but it is safe to
10 say that by far the majority of them, as with university
11 students generally, come from families of moderate or well-
12 to-do circumstances. It has been said that the cost of
13 dental education is one of the factors which discourage
14 students from entering the profession. This may be true,
15 but it is a fact that no student enrolled in dentistry for
16 the past ten years has been required to discontinue his
17 studies for financial reasons. This may mean that most
18 students from lower income families do not enter dental
19 school or even consider the possibilities of a career in
20 dentistry. It is likely that the parents of such students
21 tend to discourage their interest in the profession.

22 D55 Experience with veteran students in the
23 dental schools following the Second World War would sub-
24 stantiate the desirability of finding financial aid for
25 students who would not have been able to attend university
26 had it not been for the subsidization provided through the
27 Department of Veterans' Affairs.

28 D56 Two subsidization programmes are now avail-
29 able to students in this region. One is offered by the
30 Government of Newfoundland to students from that Province.

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1 The dental student is subsidized to the extent of twelve
2 hundred dollars a year for four years, in return for which
3 he is required to serve for four years in the province,
4 two of which must be with the Provincial Public Health
5 Department. The other plan is that of the Royal Canadian
6 Dental Corps in which almost the entire cost of dental
7 education, plus pay and allowances, and other benefits are
8 provided for students who undertake to serve in the Corps
9 for a period of five years.

10 D57 Both of these programmes have excellent
11 merit. They provide personnel for the departments, and an
12 educational opportunity for students who might not be able
13 to undertake the programme of studies. On the other hand,
14 the plans do have limitations. The potential pool of
15 practitioners for the area is reduced by the Army plan,
16 and in both schemes some potential teachers, research
17 workers, and specialists are diverted from early entrance
18 into the area of their special aptitudes, and may never
19 return to it.

20 D58 Dental Personnel in the Atlantic Region

21 Present situation: As the major source
22 of dental personnel for the region, the Faculty must make
23 all possible effort to fulfill requirements. It therefore
24 seems appropriate to comment on the present personnel situa-
25 tion.

26 D59 The following Tables are prepared from in-
27 formation obtained through the central office of the Cana-
28 dian Dental Association to show

29 (a) the more recent ratios of population per
30 dentist in each of the Atlantic Provinces
and Canada as a whole, and



The dental student is subsidized to the extent of twelve months salary for the first year, and for the next two years he is required to serve for four years in the province, two of which must be with the Provincial Public Health Department. The other plan is that of the Royal Canadian Mounted Corps in which students are required to serve for a period of five years.

Both of these plans have their merits. They provide personnel for the department, and an educational opportunity for students who might not be able to pursue the programme of studies. On the other hand, the plans do have limitations. The potential pool of practitioners for the area is reduced by the Army plan, and specialists are diverted from early entrance into the area of their special aptitudes, and may never return to it.

Dental Personnel in the Atlantic Region

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The following tables are prepared from the

Atlantic Dental Association to show

(a) the more recent ratios of population per dentist in each of the Atlantic Provinces and Canada as a whole, and



(b) the number of practising dentists in each of the Atlantic Provinces, and in Canada as a whole, from 1938 to the present:

Population per Dentist for 10-year Period 1952-61*

Year	Nfld.	N. B.	N. S.	P.E.I.	Canada
1952	17,038	4656	3257	3372	2740
1953	15,059	4564	3262	2983	2686
1954	11,969	4621	3348	3118	2790
1955	12,061	4597	3399	3000	2838
1956	11,771	4574	3449	3273	2881
1957	10,643	4437	3600	2920	2934
1958	10,390	4520	3675	2913	2981
1959	9,522	4653	3737	3030	2963
1960	10,441	5175	3710	2914	3018
1961	10,929	5000	3689	3323	3037

*From Canadian Dental Association - as of January First in given year.

Number of Practising Dentists - Atlantic Provinces and Canada as a whole

Year	Nfld.	N. B.	N. S.	P.E.I.	Canada
1938	*	110	169	30	4174
1943		71	133	22	3284
1947		114	180	28	4602
1948		167	177	24	3726
1949		112	178	29	4549
1950	19	105	171	29	4627
1951	21	106	192	30	4912
1952	21	110	196	29	5071
1953	24	113	197	33	5215
1954	32	116	198	34	5298
1955	33	119	198	35	5354
1956	35	122	198	33	5416
1957	39	125	193	34	5481
1958	41	125	191	34	5564
1959	46	124	190	33	5753
1960	43	114	193	35	5780
1961	42	120	196	31	5865

*Figures not available prior to Confederation.

D60 It can be seen that the ratio of population per dentist in each of the Atlantic Provinces is much higher than the Canadian average. In general, with the possible exception of one of the Western Provinces, the situation is much less favourable in the Atlantic region than in any other area of Canada

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*Figures not available prior to Confederation.

Year	Nfld.	N. B.	N. S.	P. E. I.	Canada
1961	42	120	196	31	2665
1960	43	114	193	32	2780
1959	46	124	190	33	2753
1958	41	125	181	34	2565
1957	39	125	193	34	2481
1956	35	122	188	33	2475
1955	33	119	198	32	2324
1954	32	116	198	34	2306
1953	24	113	197	33	2215
1952	21	110	196	29	2071
1951	21	106	192	30	1910
1950	19	105	171	29	1657
1949		112	178	29	1503
1948		107	177	24	1286
1947		114	180	28	1009
1946		71	133	25	9244
1945	*	110	169	30	4174

Number of Practising Dentists - Atlantic Provinces and Canada as a whole

*From Canadian Dental Association - as of January First in given year.

Year	Nfld.	N. B.	N. S.	P. E. I.	Canada
1961	10,252	5000	3689	3552	3017
1960	10,441	5175	3710	3514	3018
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1954	11,969	4621	3348	3118	2750
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1952					2700

Population per Dentist for 10-year Period 1952-61 *

(b) the number of practising dentists in each of the Atlantic Provinces, and in Canada as a whole, from 1938 to the



1 D61 In recent years there has been some im-
2 provement in the population per dentist in Newfoundland,
3 and little change in Prince Edward Island, but there has
4 been a more or less recession for both New Brunswick and
5 Nova Scotia.

6 D62 Requirements: Comprehensive statistical
7 information is not available, but it is our belief that den-
8 tal health in this region is also much less favourable
9 than in other parts of the country. While one would ex-
10 pect such a situation to exist because of the relative
11 shortage of dentists, we suspect, without the means to
12 prove our case, that other factors, possibly diet, heredity,
13 economics, etc. contribute to a disproportionately high in-
14 cidence of dental disease. If personnel and money were
15 available, the validity of this impression together with
16 possible reasons and solutions, should be investigated.

17 D63 What the population per dentist should be is
18 not known, for it is related not only to need but to actual
19 demand for dental services, and statistics are not avail-
20 able. Demand will vary from one region to another depend-
21 ing on availability of service, the level of education,
22 and the economic conditions in the area. It seems reason-
23 able to expect, however, that the number of dentists in
24 the Atlantic Provinces should, at least, be as favourable
25 as in other parts of Canada, namely, one to 3,037.

26 D64 The Royal Canadian Dental Corps establish-
27 ment is on the basis of one dentist for every 750 service
28 personnel. In the United States the present population per
29 dentist of approximately 1,900 is considered far from ade-
30 quate. According to the recently completed "Survey of Den-

D61

In recent years there has been some improvement in the population per dentist in Newfoundland, and little change in Prince Edward Island, but there has been a more or less recession for both New Brunswick and

D62

Requirements: Comprehensive statistical

information is not available, but it is our belief that dental health in this region is also much less favourable than in other parts of the country. While one would expect such a situation to exist because of the relative shortage of dentists, we suspect, without the means to prove our case, that other factors, possibly diet, heredity, economics, etc. contribute to a disproportionately high incidence of dental disease. If personnel and money were available, the validity of this impression together with possible reasons and solutions, should be investigated.

What the problem is in this area is not known, for it is related not only to need but to actual demand for dental services, and statistics are not available. Demand will vary from one region to another depending on the economic conditions in the area. It seems reasonable to expect, however, that the number of dentists in the Atlantic Provinces should, at least, be as favourable as in other parts of Canada, namely, one to 2,037.

D64

The Royal Canadian Dental Corps establishment is on the basis of one dentist for every 750 service personnel. In the United States the present population per dentist of approximately 1,900 is considered far from adequate.



1 tistry in the United States"(1), it is stated:

2 "This latter study reported that national
3 expenditures for dental care increased by
4 50 percent during the five-year period of
5 the year of the study, 1957-58. Taking
6 into consideration increases in population
7 and in dental fees, the Health Information
8 Foundation report indicates an increase of
9 22 percent in the amount of dental care re-
10 ceived per capita during the five-year per-
11 iod. Should this trend continue, total con-
12 sumption of dental care in 1975 will be
13 about 120 percent higher than in 1958."

14 "Should the prediction of the level of future
15 demand be overstated by half, the problem
16 of assuring adequate dental manpower in
17 1975 still would represent a Herculean task.
18 In fact, to train in the brief period of
19 fifteen years the number of dentists needed
20 to meet even a part of the tremendous in-
21 crease in demand is an almost impossible
22 undertaking."

23 D65 There is no reason to believe that the in-
24 cidence of dental diseases in this country is less than it
25 is in the United States. Dental personnel requirements,
26 on the other hand, may be less than in the United States,

27 (1) Survey of Dentistry, The Final Report, Commission on
28 the Survey of Dentistry in the United States; 1961;
29 American Council on Education, Washington, D.C., pp.81,
30 83.

istry in the United States" (1), it is stated:

"This latter study reported that national expenditures for dental care increased by 50 percent during the five-year period of the year of the study, 1957-58. Taking into consideration increases in population and in dental fees, the Health Information Foundation report indicates an increase of 25 percent in the amount of dental care received per capita during the five-year period. Should this trend continue, total consumption of dental care in 1975 will be about 150 percent higher than in 1958."

"Should the prediction of the level of future demand be overstated by half, the problem of assuring adequate dental manpower in 1975 still would represent a Herculean task. In fact, to train in the brief period of fifteen years the number of dentists needed to meet even a part of the tremendous increase in demand is an almost impossible undertaking."

There is no reason to believe that the incidence of dental diseases in this country is less than it is in the United States. Dental personnel requirements, on the other hand, may be less than in the United States. (1) Survey of Dentistry, The Final Report, Commission on the Survey of Dentistry in the United States; 1961; American Council on Education, Washington, D.C., pp. 81, 83.



1 but only as a result of limitations imposed by economic
2 resources of the country and its individuals, and a lack
3 of appreciation for the necessity of dental care--dental
4 health education.

5 D66 Further evidence of the acute problems as-
6 sociated with the provision of dental health service is
7 the almost complete absence of practising specialists. In
8 the four Provinces there are only six Orthodontists (four
9 in Nova Scotia, two in New Brunswick), one Oral Surgeon,
10 no Periodontists, no Paedodontists, and no Prosthodontists.

11 D67 One out of 800 children is born with a
12 cleft palate, and yet there is no center for the manage-
13 ment of such cases, most of which require the cooperative
14 services of the surgeon, the paediatrician, dental specia-
15 lists, the speech therapist, and the psychologist. A few,
16 the more fortunate people, who require specialized atten-
17 tion are able to finance trips to the nearest treatment
18 centers located in Montreal or Boston. Others are given
19 the best possible service by local surgeons and dentists,
20 but many must remain untreated.

21 D68 Dental Public Health services are at a
22 minimum at the provincial levels, and practically non-ex-
23 istent in local communities. From the point of view of
24 preven tion, the public health departments unquestionably
25 are attempting to do as much as they can within the limited
26 resources and personnel at their disposal. They are faced,
27 also, with the dilemma of balancing their desire to advance
28 public education in prevention and early dental care, with
29 the fact that any appreciable increase in demand for ser-
30 vice could not be provided by the available practitioners.

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also, with the dilemma of balancing their desire to advance

public education in prevention and early dental care, with

the fact that any appreciable increase in demand for ser-

vice could not be provided by the available practitioners.



1 D69 The University does not now feel competent
2 to predict what the immediate supply of dentists should be
3 for the Atlantic Provinces. Many factors, such as econo-
4 mic conditions, implementation of prepaid or state-sup-
5 ported dental health care plans, population increases, and
6 the extension of known preventive services, and public
7 health education, will affect the relationship of demand
8 to actual need. More dentists are required, but it is
9 also certain that a sudden, substantial increase in the
10 supply of dentists, even if it were possible within the
11 space of a very few years, which it is not, would create
12 problems of full utilization, and economic difficulties
13 for the practitioners.

14 D70 The following Table shows the additional
15 number of dentists required to attain the average Canadian
16 ratios which obtained in 1938 and 1961. It is based upon
17 the population figures of March, 1961, from the Canadian
18 Statistical Review, and dental population figures supplied
19 by the Canadian Dental Association:

20 Number of Additional Dentists Required to
21 Bring the Population per Dentist to the
22 1938 and 1961 Canadian Ratios.

23 Number of additional Dentists needed
24 to attain ratios of:

25	26	Number of Registered Dentists,		
		1:2685*(1)	1:3037*(2)	1961
27	Prov.			
28	Nfld.	132	112	42
29	N.B.	106	80	120
30	N.S.	75	44	196
	P.E.I.	8	3	31
	Total	321	239	389

ported dental health care plans, population increases, and the extension of known preventive services, and public health education, will affect the relationship of demand to actual need. More dentists are required, but it is also certain that a sudden, substantial increase in the supply of dentists, even if it were possible within the space of a very few years, which it is not, would create problems of full utilization, and economic difficulties for the practitioners.

The following Table shows the additional number of dentists required to attain the average Canadian ratios which obtained in 1938 and 1961. It is based upon the population figures of March, 1961, from the Canadian Statistical Review, and dental population figures supplied by the Canadian Dental Association:

Number of Additional Dentists Required to Bring the Population per Dentist to the 1938 and 1961 Canadian Ratios.

Number of additional Dentists needed to attain ratios of:

Ratio	1938	1961	Number of additional Dentists needed
W.D.	132	112	42
N.B.	106	80	120
N.S.	75	44	136
I.	8		



* (1) Canadian Ratio in 1938

(2) " " in 1961

D71 It is evident that the present facilities could not provide, within the space of twenty years, sufficient additional dentists to reach even the present Canadian average, without regard to population increases, death and retirement rates, and other factors which would adversely influence the change.

D72 Finances

The cost of operating a dental school is probably the highest of any faculty in a university. There are three basic reasons why this is so:

(1) The teaching clinic and laboratories require a great deal of costly equipment and technical services.

(2) The cost of operating the clinic service is borne from the Faculty Budget. In medical schools the service staff and facilities for the clinical departments are usually within a hospital which is financed as a separate unit. The teaching staff, is probably charged to the Faculty of Medicine.

(3) The number of teachers, many of whom are in specialized fields, in proportion to the number of students, despite the almost gratuitous services of a very large number of part-time teachers.

D73 Annual Costs: The annual operation of the Faculty of Dentistry at Dalhousie is financed solely from student fees, Government grants, and the University's resources, including income from the operation of the dental clinic. Patient fees, which account for the latter item,

*(1) Canadian Ratio in 1938

" (2) " " in 1961

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Factors

DYS

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are in specialized fields, in proportion to the number of students, despite the almost gratuitous services of a very large number of part-time teachers.

Faculty of Dentistry at Dalhousie is financed solely from student fees, Government grants, and the University's resources, including income from the operation of the dental clinic. Patient fees, which account for the latter item,



are based primarily on the cost of materials and supplies, and not on the total cost of operating the clinic. The clinic is provided as a teaching unit, although considerable service is rendered incidentally to low-income groups of the immediate area at a nominal charge to the individuals. This service is of great benefit to the community.

D74 Comparisons of the cost per student and sources of University revenue for the academic years 1954-55, and 1961-62 are as follows:

	<u>1954-55</u>	<u>1961-62</u>
Cost per student	\$1,219.96	\$4,227.66
Income per student:		
By student fees	398.00	450.00
Government grants	428.80	2438.59
University resources	<u>393.16</u>	<u>1339.07*</u>
	\$1,219.96	\$4,227.66

* Includes a deficit for the Faculty Budget in excess of \$50,000, or about \$950 per student.

D75 The projection of the cost per student reported by the Survey of Dentistry in the United States is probably valid for Canadian schools. It is stated on page 383:

D75 "Those planning new or expanded schools should contemplate operating expenses of about \$5,000 per student per year by 1960".

D76 The cost at Dalhousie should exceed this figure, as the cost per student in a small faculty is higher than in larger schools. If this Faculty of Dentistry were to increase to a size of forty to sixty students per class, it would not be necessary to have a proportionate



1 increase in all of the costs of providing services and
2 teaching staff. Thus, the cost per student up to approxi-
3 mately sixty students per class with the same quality of
4 teaching would be somewhat less than for a class of twenty-
5 five.

6 D77 ~~The~~ four Atlantic Provinces each make an
7 annual grant to Dalhousie for the operation of the Facul-
8 ties of Medicine and Dentistry. Calculations upon which
9 the payments are made are combined for the two Faculties,
10 and more detailed information will be given subsequently
11 to indicate further the difficulties with which the Uni-
12 versity is faced in securing adequate support for the
13 operation of these two professional schools. (See para-
14 graphs lettered F).

15 D78 Capital Costs: In planning the new Dentistry
16 Building, financial support for the project was sought from
17 Federal and provincial governments, and from private re-
18 sources. As a result of the most heroic efforts for sup-
19 port, the new building was completed, equipped, and oc-
20 cupied in 1958 at a total cost of One Million, Nineteen
21 Thousand, Four Hundred Dollars (\$1,019,400). Government
22 assistance in this project accounted for less than twenty-
23 five percent of the total cost. The Government of Nova
24 Scotia provided \$150,000, and through Federal Health Grants,
25 and additional \$54,623. The Government of Newfoundland
26 made a grant of \$30,800 for equipment, but no assistance
27 was received from the Governments of New Brunswick and
28 Prince Edward Island. The bulk of the money had to be
29 raised by the University through gifts from Foundations
30 and other private donors, including One Hundred Thousand

increase in all of the costs of providing the same quality of

mainly sixty students per class with the same quality of
would be somewhat less than for a class of twenty
five.

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was received from the Government of New Brunswick and
Prince Edward Island. The bulk of the money had to be
raised by the University through gifts from Foundations
and other private donors, including one hundred thousand



1 Dollars from the W. K. Kellogg Foundation and \$38,000 from
2 the Dental profession.

3 D79 It is most unlikely that additional money
4 for capital expansion can be obtained from private sources
5 for this Faculty of Dentistry in the future.

6 D80 DENTAL HYGIENE EDUCATION

7 The training programme for Dental Hygienists
8 is in the School of Dental Hygiene, which is organized as
9 a separate division within the Faculty of Dentistry. There
10 follows a statement of its present and future position:

11 D81 Historical Background: Slightly less than
12 fifty years ago the first formal training programme in dental
13 hygiene was initiated in Bridgeport, Connecticut. The primary
14 objectives of the first school were twofold: (1) to train
15 young women to provide oral prophylactic service (scaling
16 and polishing of the teeth) for children in the public
17 schools of Bridgeport, and (2) to promote improved dental
18 health habits through individual instruction and classroom
19 talks. The success of this project demonstrated the value of
20 the dental hygienist in dental public health and also demon-
21 strated to members of the dental profession the valuable
22 contribution which the dental hygienist might make in
23 providing these services for patients in offices in which
24 the dental hygienist became one of the auxiliary dental
25 personnel, she could assume these two aspects of preventive
26 dental treatment and thus provide time which the dentist
27 could utilize to perform other treatment services for his
28 patients. The profession of dental hygiene has grown steadily
29 in the United States and the movement to educate young women
30 to become dental hygienists has spread to Canada and other
countries.

... from the W. K. Kellogg Foundation and \$28,000 from

DENTAL HYGIENE EDUCATION

Doc

The training program for Dental Hygienists is in the School of Dental Hygiene, which is organized as a separate division within the Faculty of Dentistry. There follows a statement of its present and future position:

Fifty years ago the first formal training program in dental

hygiene was established in the United States.

Young women to provide oral prophylactic services (scaling

and polishing of the teeth) for patients in the dental

office.

Health habits through individual instruction and classroom

talks. The success of this project demonstrated the value of

the dental hygienist in dental public health and also demon-

strated to members of the dental profession the value of

collaboration which the dental hygienist might make in

providing these services for patients in offices in which

the dental hygienist became one of the auxiliary dental

personnel, and could assume these two aspects of preventive

dental treatment and thus provide time which the dentist

could utilize to perform other treatment services for his

patients. The profession of dental hygiene has grown steadily

in the United States and the movement to educate young women

to become dental hygienists has spread to Canada and other

countries.



D82

Origin: Several factors prompted the con-

sideration of the establishment of an educational programme in dental hygiene within the Faculty of Dentistry at Dalhousie University. Among the more important of these factors were:

(1) increased employment opportunities in private dental practices, (2) increased employment opportunities in dental public health programmes sponsored by provincial departments of public health, (3) provision of educational opportunities for young women of the Atlantic Provinces and (4) a means of providing the dental student with some experience in working with the dental hygienist who, at this level of her training, serves as a chairside assistant as well as in the areas of professional dental service traditionally assigned to her. In summary, it was believed that the establishment of a School of Dental Hygiene at Dalhousie University, would assist in providing a further extension and an improvement of dental health services within the community of the Atlantic Provinces.

D83 Physical Facilities: At the time of planning for the construction of the new building for the Faculty of Dentistry, provision was made for students in dental hygiene. While excellent physical facilities were provided, it remained to obtain financial support for the proposed educational programme.

D84 Financial Support: The funds necessary for the initiation and the operation of a School of Dental Hygiene for a period of three years were secured from the W.K. Kellogg Foundation, Battle Creek, Michigan. Funds for the first year included a sum for capital expenditures: in-

Original: Several factors prompted the con-

struction of the establishment of a dental hygiene school at Dalhousie University. Among the more important of these factors were:

- (1) Increased employment opportunities in private dental offices.
 - (2) Provision of educational opportunities for young women of the Atlantic Provinces and (4) a means of providing the dental student with some experience in working with the dental physician who, at this level of her training, serves as a valuable assistant as well as in the areas of professional dental hygiene traditionally assigned to her. In summary, it was believed that the establishment of a School of Dental Hygiene at Dalhousie University, would assist in providing a further expansion and an improvement of dental health services within the community of the Atlantic Provinces.
- Physical Facilities: At the time of planning for the construction of the new building for the Faculty of Dentistry, provision was made for students in dental hygiene. While excellent physical facilities were provided, it remained to obtain financial support for the proposed educational programme.

Financial Support: The funds necessary for the initiation and the operation of a School of Dental Hygiene for a period of three years were secured from the W.K. first year included a sum for capital expenditures; in-



struments, educational films, reference books, and other items necessary to implement the programme. Funds for the first year of operation were granted on the basis of an initial class of eight students. Cost was estimated at \$2299 per student. The amount of the grant for the second year of operation was based on estimated costs for a total of twenty students (eight second year, twelve first year) and amounted to \$1239 per student. For the third year, the amount of the grant was based on cost of operation for twenty-four students and amount to \$1070 per student.

D85 Course Content: The two-year course leading to a Diploma in Dental Hygiene offered at Dalhousie University was established on the traditional curricula. The courses which comprise the educational programme may be classified as scientific, general, clinical, and laboratory. The basic science courses are largely concentrated in the first year of study with the more specifically dental hygiene courses and the clinical practice of skills emphasized in the second year.

D86 Admission: Qualifications for admission to the course of study are the same as for all other students applying for admission to undergraduate programmes at Dalhousie University, namely: the satisfactory completion of specified subjects of junior matriculation.

D87 Enrolment: The first class of eight students represented three of the four Atlantic Provinces. As the School of Dental Hygiene was established to serve the Atlantic Provinces, it is hoped that in future classes there will be students from each of the four Provinces. Five of the eight students are on bursaries from their provincial



governments and will be employed in dental public health upon their graduation. It is anticipated that the remaining number of graduates will be employed in the offices of private dental practitioners.

D88 Future Support: Through the support of the W.K. Kellogg Foundation, the operation of the first three years of the school is assured. Upon expiration of the grant on June 30, 1964, the financial support for the programme will have to be obtained from other sources: the operating budget of Dalhousie University and grants from the national and provincial governments. Should all costs--salaries, operation of the physical plant, teaching materials, instruments and equipment--remain the same, it is estimated that the cost per student will be from \$1100 to \$1300 per year. Capital expenditures are difficult to predict, but, in time, equipment and instruments will need to be replaced and facilities expanded. The physical space now available could, with slight alteration and installation of additional equipment, provide for classes of fourteen students.

D89 Demand: It is anticipated that within a few years time, there will be an ever increasing demand for the professional services of the graduate dental hygienist as well as an increase in the number of qualified students seeking admission to the educational programme. It is with these factors in mind that note is made of anticipated future needs.

D90 PROJECTIONS AND RECOMMENDATIONS

There is need for much more generous financial assistance for the operation of the present Dental Faculty,

Future plans : ...

years of the school in ...

and will have to be ...

operating budget of ...

national and provincial ...

estimated that the ...

\$1300 per year. ...

to be replaced and ...

now available ...

tion of additional ...

teen students.

years time, ...

the professional ...

as well as an ...



and on a more stable basis (also see subsequent sections- paragraphs F). Present deficits must be eliminated (para. D74). More, qualified teachers - particularly on a full-time basis, are required now (para. D36), as well as for any future increase in the size of the school, and technical staff who would contribute to an increase in the efficiency and effectiveness of the teaching programme (para. D36). Salaries of teachers should be improved immediately (paras. D32, D33, D34).

D91 There should be an immediate improvement in the facilities for the teaching of dental students in hospitals.

D92 To stimulate the development of dental research staff (paras. D23, D28) and teachers, it is recommended that money be provided to subsidize persons engaged in advanced education programmes for these purposes.

D93 An extension of short post-graduate and refresher courses should be developed now, but graduate and specialty education in dentistry is not possible at Dalhousie until there has been an appreciable increase in the size of the Faculty (para. D24).

D94 At such time as the class size is sufficiently large (forty to sixty students), basic science departments (Bacteriology, Biochemistry, Microscopic Anatomy, Pathology, Pharmacology, Physiology), with adequate research facilities, should be established as an integral part of the Dental Faculty (para. D9). For many reasons it may be desirable for the medical department of anatomy to continue to offer the instruction in gross anatomy.

D94 Based upon experience in this University,

to offer the instruction in gross anatomy.

desirable for the medical department of anatomy to continue

Dental Faculty (para. D5). For many reasons it may be

ties, should be established as an integral part of the

large (forty to sixty students), basic science department.

the size of the Faculty (para. D4).

Dalhousie until there has been an appreciable increase in

and specialty education in dentistry is not possible at

refresher courses should be developed now, but graduate

D3 An extension of short post-graduate and

in advanced education programmes for these purposes.

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D2 To stimulate the development of dental re-

the facilities for the teaching of dental students in hos-

D1 There should be an immediate improvement in

D32, D33, D34).

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staff who would contribute to an increase in the efficiency
any future increase in the size of the school, and technical

time basis, are required now (para. D36), as well as for

D4). More, qualified teachers - particularly on a full-

paragraph F). Present deficits must be eliminated (para.



much more generous financial assistance is required for the adequate operation of existing and projected dental schools, and for capital needs. Depending on the size of the school, it is estimated that an additional \$2,000 per student is required for annual operation, and \$20,000 per student for new capital construction, which could include separate basic science departments for the Faculty of Dentistry. It is highly improbable that these amounts can be secured from private sources. Since graduates of the dental school may choose to practice in any area in Canada, it is recommended that the Federal Government provide financial assistance both for operation and capital construction of dental schools.

D95 It is estimated that only one-fifth to one-third of the Canadian population now receives dental care in a given year. It is known that only five percent of the population is unaffected by dental diseases, but more information is needed relative to annual need and demand for dental services.

D96 It is recommended, therefore, that a reliable study be undertaken to determine the relative need and demand for dental care, so that projections of personnel requirements may be prepared on a realistic basis. Such a study should include consideration of the possible effects of pre-paid and state-supported dental care programmes.

D97 There is need to increase the number of dental practitioners in the Atlantic region (paras. D58-D71). Increasing university enrolment and recruitment activity may improve the present inadequate numbers of students in dentistry, but it appears that additional incentives are

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Increasing university enrolment and recruitment activity may improve the present inadequate numbers of students in dentistry, but it appears that additional incentives are



necessary to assure the required number and quality of students (paras. D46 to D57). It is recommended that these incentives include:

D98 (1) Annual scholarships, each in the amount of \$1,500 To \$2,000, for the four years in the Faculty of Dentistry, to permit the Dental Faculty to compete with other areas of advanced education for students with high academic standing.

D99 (2) A number of substantial bursaries for needy students which would assist them for at least the four-year period in the Faculty of Dentistry. To be effective, the amount should be about \$1,000 a year, which, if added to summer earnings, would cover the \$1,500 or \$2,000 per year which students estimate is their personal annual cost. Such bursaries should be on a national basis, preferably with 'no strings' other than an undertaking to serve in Canada.

The University does not now have funds to provide either of these incentives.

D100 (3) Student subsidies similar to those provided by the Royal Canadian Dental Corps, sufficient to cover the cost of dental education and living expenses, in return for which the student would agree to some form of public service for a specified number of years.

D101 The first two methods are to be preferred, because they allow the graduate to have greater freedom in the selection of a career, whether it be general or specialized practice, research, teaching, or public health.

D102 Because of the shortage of dental personnel, implementation of a full programme of state-financed dental care seems impractical at this time. Any state dental

students (para. D46 to D57). It is recommended that these

incentives include:

D58 (1) Annual scholarships, each in the amount

of \$1,500 To \$2,000, for the four years in the Faculty of

Dentistry, to permit the Dental Faculty to compete with

academic standing.

D59 (2) A number of substantial bursaries for

needy students which would assist them for at least the

four-year period in the Faculty of Dentistry. To be ef-

fective, the amount should be about \$1,000 a year, which,

if added to summer earnings, would cover the \$1,500 or

\$2,000 per year which students estimate is their personal

annual cost. Such bursaries should be on a national basis

preferably with 'no strings' other than an undertaking to

serve in Canada.

provide either of these incentives.

D100 (3) Student subsidies similar to those pro-

vide the cost of dental education and living expenses, to

public service for a specified number of years.

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because they allow the graduate to have greater freedom

the selection of a career, whether it be general or spe-

implementation of a full programme of state-financed den-



1 care plan should be preceded by a programme which will
2 provide greatly increased numbers of dentists.

3 D103 Further, any solution to the manpower prob-
4 lem which results in a lowering of professional standards
5 of dental care, will compound the difficulties by discour-
6 aging recruitment to the profession, and a deterioration
7 in the dental schools.

8 D104 It cannot be emphasized too strongly that from
9 the day a decision is reached to provide a new school, a
10 minimum of six years will elapse before the first student
11 graduates from it. This includes time for planning and
12 construction, recruitment of staff and a minimum of four
13 years required to educate a dental student.

14 D105 In considering any extension of facilities
15 for dental education in the Atlantic Provinces, the follow-
16 ing points are pertinent:

17 (a) The Faculty of Dentistry at Dalhousie is
18 now providing the majority of dentists for the region(para.
19 D46), and it is able to accommodate twice as many qualified
20 students as now seek admission from the Atlantic Provinces
21 (para. D48).

22 (b) The first step in a programme for the
23 expansion of dental education facilities in the Atlantic
24 region should be an increase in the size of the existing
25 school.

26 (c) It has been suggested that the facilities
27 of the dental schools be utilized more efficiently by of-
28 fering classes for eleven months of the year, rather than
29 the present eight and one-half to nine months, thereby
30 reducing the number of calendar years required to complete

care plan should be preceded by a programme which will

provide greatly increased numbers of dentists.

D103 Further, any solution to the manpower problem which results in a lowering of professional standards of dental care, will compound the difficulties by discouraging recruitment to the profession, and a deterioration in the dental schools.

D104 It cannot be emphasized too strongly that from

minimum of six years will elapse before the first student graduates from it. This includes time for planning and construction, recruitment of staff and a minimum of four years required to educate a dental student.

D105 In considering any extension of facilities for dental education in the Atlantic Provinces, the following points are pertinent:

(a) The Faculty of Dentistry at Dalhousie is now providing the majority of dentists for the region (para. D46), and it is able to accommodate twice as many qualified students as now seek admission from the Atlantic Provinces

(para. D47)

(b) The first step in a programme for the expansion of dental education facilities in the Atlantic region should be an increase in the size of the existing school.

(c) It has been suggested that the facilities of the dental schools be utilized more efficiently by offering classes for eleven months of the year, rather than the present eight and one-half to nine months, thereby reducing the number of calendar years required to complete



1 the course of study--although not the total teaching time.
2 This might be possible, but not without a significant in-
3 crease in the teaching staff and other personnel for whom
4 there is no physical accommodation at present, and under
5 the present circumstances only if the basic science classes
6 for medical and dental students could be adjusted.

7 (d) The University is not aware of any authori-
8 tative evidence to determine the optimal size of a dental
9 school from the points of view of economy and most effective
10 teaching. It is the Faculty's opinion, however, that greater
11 economy could be achieved with a class size of sixty stu-
12 dents, but that this figure should not be exceeded. To do
13 so would result in less efficiency until classes of approxi-
14 mately one hundred and twenty were reached, but even more,
15 a close personal relationship between the teacher and stu-
16 dent would be impossible. The Faculty must be in a position
17 not only to assess the student's intellectual and technical
18 skill, but his ability to develop rapport with his patients.

19 (e) The size and location of the dental
20 school is determined, in part, by the necessity that it
21 be an integral part of the university, and by the size of
22 the community in which it is located. It is doubtful whether
23 an urban population appreciably less than 100,000 would
24 provide the number of patients for the variety of teaching
25 experience in the clinical programme.

26 D106 Part of the personnel problem can be solved
27 by the more extensive use of auxiliaries in practice. These
28 include the dental assistant, the dental hygienist, and
29 the dental technician. Training programmes for these
30 groups should be developed.

the course of study--although not the total teaching staff. This might be possible, but not without a significant increase in the teaching staff and other personnel for whom there is no physical accommodation at present, and under the present circumstances only if the basic science classes for medical and dental students could be adjusted.

(d) The University is not aware of any other

school from the point of view of economy and most efficient teaching. It is the Faculty's opinion, however, that greater economy could be achieved with a class size of thirty students, but that this figure should not be exceeded. To do so would result in less efficiency and a loss of respectability one hundred and twenty were needed, but even more a close personal relationship between the teacher and student would be impossible. The Faculty must be in a position not only to assess the student's intellectual and technical skill, but his ability to develop rapport with his patients.

(e) The size and location of the dental

school is determined, in part, by the necessity that it be an integral part of the university, and by the size of the community in which it is located. It is doubtful whether an urban population appreciably less than 100,000 would provide the number of patients for the variety of teaching experience in the clinical programme.

Part of the personnel problem can be solved by the more extensive use of auxiliaries in practice. These include the dental assistant, the dental hygienist, and

groups should be developed.



1 D107 Within two years, this University will re-
2 quire support for its dental hygiene programme in the amount
3 of approximately \$700 per student per year (para. D88).

4 D108 It is reasonable to expect that auxiliaries
5 can be trained to do more of the technical procedures un-
6 der the direct responsibility of the dental practitioner,
7 than is now legally permissible. This possibility should
8 be explored on an experimental basis, to determine the ex-
9 tent to which additional duties can be assigned in an ef-
10 fective and economically sound manner.

11 D109 It is recommended that a system of Federal-
12 Provincial Public Health Grants be implemented, specifical-
13 ly for dental health problems, similar to those available
14 for medicine. These should provide funds for clinical re-
15 search and other studies such as the project suggested in
16 paragraph D108, for specialized treatment centers such as
17 cleft palate clinics, diagnostic centers (particularly in
18 orthodontics and other specialty areas) and the extension
19 of dental public health services.

D107

Within two years, this University will re-

D108

of approximately \$700 per student per year (para. D88).
It is reasonable to expect that auxiliaries

can be trained to do more of the technical procedures under the direct responsibility of the dental practitioner, than is now legally permissible. This possibility should be explored on an experimental basis, to determine the extent to which additional duties can be assigned in an effective and economically sound manner.

D109

It is recommended that a system of Federal-Provincial Public Health Grants be implemented, specifically for dental health problems, similar to those available for medicine. These should provide funds for clinical research and other studies such as the project suggested in paragraph D108, for specialized treatment centers such as orthodontics and other specialty areas) and the expansion of dental public health services.



FINANCING OF THE FACULTIES OF MEDICINE AND DENTISTRY

F-1 The introductory section of this brief indicated that Dalhousie Medical School was introduced to the cold hard problems of financial insolvency when it was only five years old. It surmounted its first major crisis in 1920 with an endowment from the Rockefeller and Carnegie Foundations.

F-2 The second major financial crisis for the Faculties of Medicine and Dentistry occurred after World War II when costs were spiralling, needs for staff were great and the provincial grants were very small. In fact, it was only in 1947 that two of the four Provinces had first recognized their responsibility for supporting medical and dental education.

F-3 A few details of later negotiations with the Provincial Governments and the search for funds from other sources will be described to emphasize the high cost of medical and dental education, the need to maintain high standards and the problems resulting from the instability of provincial grants.

 From 1947 to 1954 the provincial grants remained at the level of \$115,000. In 1954 a further approach was made to the Governments of the four Provinces, indicating that a substantial increase in support was required because of the existing deficits and the obvious fact that both Faculties would have to improve very markedly in order to meet the requirements of accrediting agencies. Without increased support it would be impossible to obtain staff or provide a reasonable quality of education for the students of this region.

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War II when costs were spiralling, needs for staff were



1 F-5 The Provinces were requested to provide in-
2 creases of \$143,000, allocated on the basis of the average
3 number of students in attendance in the Faculties of Medi-
4 cine and Dentistry from the respective Provinces over the
5 previous five-year period. Nova Scotia was asked to bear
6 a higher proportion than the other three Provinces, in rec-
7 ognition of certain incidental benefits to the province in
8 which the schools are located.

9 F-6 Increases of \$103,000 were granted, which
10 permitted some but not all of the necessary improvements.
11 The major amounts were provided by Nova Scotia and New-
12 foundland. With these increases the total provincial
13 grants in 1957 amounted to \$218,000.

14 F-7 In 1957 an approach was again made to the
15 four Governments, and to the Premiers' Conference of that
16 year. A three-year programme for the period 1957 to 1960
17 was presented, indicating a need for further increases in
18 Provincial Government grants amounting to \$300,000 per
19 annum by 1960, to bring the total to \$618,000. Again the
20 Provinces were asked to provide grants in proportion to the
21 number of medical and dental students at Dalhousie from
22 each Province enrolled in the preceding five-year period.
23 They were also asked to consider a method by which the four
24 Governments could evaluate jointly the requirements of
25 these Faculties and establish a definite system for sharing
26 the costs.

27 F-8 The grants were increased by three of the
28 provinces but no inter-provincial arrangement for sharing
29 the costs was made. The University must still make an in-
30 dividual appeal annually to each of the four Governments.

number of students in attendance in the Faculties of Medicine and Dentistry from the respective Provinces over the previous five-year period. Nova Scotia was asked to bear a higher proportion than the other three Provinces, in recognition of certain incidental benefits to the province in which the schools are located.

T-6
Increases of \$103,000 were granted, which permitted some but not all of the necessary improvements. The major amounts were provided by Nova Scotia and Newfoundland. With these increases the total provincial grants in 1957 amounted to \$218,000.

T-7
In 1957 an approach was again made to the four Governments, and to the Premier's Conference of that year. A three-year programme for the period 1957 to 1960 was presented, indicating a need for further increases in Provincial Government grants amounting to \$300,000 per annum by 1960, to bring the total to \$518,000. Again the Provinces were asked to provide grants in proportion to the

number of medical and dental students at Dalhousie from each Province enrolled in the preceding five-year period.

Governments could evaluate jointly the requirements, these Faculties and establish a definite system for sharing the costs.

T-8
The grants were increased by three of the provinces but no inter-provincial arrangement for sharing the costs was made. The University must still make an individual appeal annually to each of the four Governments.



F-9 In 1957 the Provinces of Newfoundland and Nova Scotia both acceded to the request of the University and provided grants representing their share of the requested \$300,000. The Government of the Province of Prince Edward Island increased its grant from \$12,000. to \$25,000. per annum, and indicated a willingness to consider the matter further. The Government of the Province of New Brunswick has not raised its grant since 1955. The total increase from the three provinces was \$208,653. instead of \$300,000. requested. In 1960 the Provincial Government grants had therefore reached a total of \$426,653.

F-10 A Royal Commission on Higher Education was set up in 1961 by the Government of New Brunswick. Dalhousie University is presenting a brief requesting adequate support for the Faculties of Medicine and Dentistry.

F-11 The cost per student in the two Faculties based on actual expenditures and total enrolment in 1960-61 was \$2,928.76. Several positions were unfilled during a part or all of the year, thus reducing this actual cost from what it would have been with a full staff complement. This figure did not include expenditures for research, capital projects for building, for the operation of the Public Health Clinic or for the post-graduate programmes in psychiatry and continuing medical and dental education. This is a figure for under-graduate medical and dental education alone. Based on the known 1961-62 registration and the approved budgets for the two Faculties the cost per student this year will be \$3379.19.

F-12 The following table shows the grants per student from each province and the proportion of the es-

F-9

In 1977 the Provinces of Newfoundland and Nova Scotia both acceded to the request of the University and provided grants totalling their share of the total of \$300,000. The Government of the Province of Prince Edward Island increased its grant from \$12,000 to \$25,000 per annum, and indicated a willingness to consider the matter further. The Government of the Province of New Brunswick has not raised its grant since 1955. The total increase from the three provinces was \$207,000, instead of \$100,000 requested. In 1960 the Provincial Government grants had therefore reached a total of \$207,000.

F-10

A Royal Commission on Higher Education was set up in 1961 by the Government of New Brunswick. The Royal University is presenting a brief requesting additional support for the Faculties of Medicine and Dentistry.

F-11

The cost per student in the two Faculties based on actual expenditures and total enrolment in 1960-61 was \$2,928.76. Several positions were unfilled during a part or all of the year, thus reducing this actual cost from what it would have been with a full staff complement. This figure did not include expenditures for research, capital projects for building, for the operation of the Public Health Clinic or for the post-graduate programmes in psychiatry and continuing medical and dental education. This is a figure for under-graduate medical and dental education alone. Based on the known 1961-62 registration and the approved budgets for the two Faculties the cost per

F-12

The following table shows the grants per student from each province and the proportion of the total



1 timated cost for 1961-62 which these grants will cover.

Medical & Dental

2 Province	Grant in 1960	Students from each province	Grant Per Student
3 N.S.	\$294,566	123	\$2,394.80
4 N.B.	30,000	56	535.70
5 Nfld.	77,087	39	1,978.30
6 P.E.I.	25,000	29	861.30

7			
8 Totals and	\$26,653	247	\$1,727.35
9 Averages			

10 Proportion of cost
11 per Student

12 N.S. 70.8

13 N.B. 15.8

14 Nfld. 58.2

15 P.E.I. 25.7

16 Total 51.1

17 F-13 The 1959 calculation that an increase of
18 \$300,00 would be needed by 1960 was in fact an under-esti-
19 mate. Although additional Government grants of \$208,653.
20 were provided, budgeted costs went up \$344,100. For the
21 following reasons the Medical and Dental Schools were able
22 to continue in operation and to make some progress without
23 the requested increase from New Brunswick and with only a
24 partial increase from Prince Edward Island:

- 25 (a) Several essential staff appointments were delayed.
- 26 (b) Grants were obtained from the W.K. Kellogg Foundation
27 to start several essential projects. All of these
28 are on a short-term basis and must be met from other
29 sources. Indeed, some grants have now expired.
- 30 (c) Some endowment funds increased in value.

Estimated cost for 1961-62 which these grants will cover.

Medical & Dental

Students from Grant per

Province	Students	Grant per Student	Total
N.S.	123	\$2,394.60	\$294,566
N.B.	56	535.70	30,000
P.E.I.	29	861.30	25,000
Totals and	208	\$1,791.35	\$26,652

Proportion of cost per Student

N.S.	70.8
N.B.	15.8
P.E.I.	25.7
Total	112.3

F-13 The 1959 calculation that an increase of

\$300,00 would be needed by 1960 was in fact an under-estimate. Although additional Government grants of \$208,652

were provided, budgeted costs went up \$344,100. For the

following reasons the Medical and Dental Schools were able to continue in operation and to make some progress without the requested increase from New Brunswick and with only a

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- (c) Some endowment funds increased in value.

on a short-term basis and must be met from other sources. Indeed, some grants have now expired.



(d) The Federal grants for education were increased. However, these cover only a tiny fraction of the cost of educating a student in Medicine or Dentistry. In 1960-61 the Federal grant per student to Dalhousie was \$184.00. Unless it is changed it will represent only 5.5 per cent of the cost per medical and dental student in 1961-62.

F-14 If all provinces had met the request for increases between 1957 and 1960, the additional amounts available would scarcely meet the anticipated deficits for the current session.

F-15 The increased income obtained by the University from 1954 to 1960 by way of Provincial grants totalled \$688,677. for the operation of the undergraduate medical and dental programmes. During the same period the University added to its income from the two Faculties a total of \$721,666. from all other sources except the Federal grants for education and for research. Although Provincial grants gave invaluable assistance toward the operating costs, the University did not depend wholly upon them but in fact more than matched them.

F-16 In addition, grants for research in Medicine and Dentistry during that period increased by a total of \$675,731., most of which came from Federal Government sources.

F-17 Furthermore, the University obtained for capital construction of the Dental Building and remodelling of the Medical Buildings a total of \$923,977., while Provincial grants for the same purposes amounted to \$235,423. To this latter should be added the contribution by the Govern-

(b)

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and dental programmes. During the same period the University

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for education and for research. Although Provincial grants

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and Dentistry during that period increased by a total of

\$65,731, most of which came from Federal government

sources.

Furthermore, the University obtained for

capital construction of the Dental Building and remodeling

of the Medical Buildings a total of \$223,977, while Provin-

cial grants for the same purposes amounted to \$22,423. To

this latter should be added the contribution by the Govern-



1 ment of Nova Scotia of space in the new Pathology Institute,
2 which is estimated at approximately \$250,000.

3 F-18 The large additional sums required for capi-
4 tal and operation cannot be provided unless a much greater
5 proportion is borne by Government. The University cannot
6 continue to provide increasing funds from private resources
7 for these two Faculties, at the rate achieved in recent
8 years.

ment of Nova Scotia of space in the new Pathology Institute
which is estimated at approximately \$250,000.

The large additional sums required for capital and operation cannot be provided unless a much greater

continue to provide increasing funds from private resources
for these two facilities, at the rate achieved in recent

years.



FACULTY OF HEALTH PROFESSIONS

H1 Dalhousie's Faculty of Health Professions was created in 1961 to bring under one faculty the College of Pharmacy, the School of Nursing, and the proposed Schools of Physiotherapy and Occupational Therapy which have already been approved by the Board of Governors and the Senate of The University, and also to include any other para-medical groups or divisions which may be added to take care of future needs.

College of Pharmacy

H2 The first training in pharmacy in Nova Scotia began in 1908. From 1908 until 1911, evening classes were conducted in the Nova Scotia Technical College. In 1911, the Nova Scotia College of Pharmacy was established and was affiliated with Dalhousie University. In 1917, the New Brunswick Pharmaceutical Society united with the Nova Scotia Pharmaceutical Society in the operation of the college and the name was changed to "Maritime College of Pharmacy". In 1950, the Board of Trustees of the Maritime College of Pharmacy admitted the Prince Edward Island Pharmaceutical Association to affiliation with the Maritime College of Pharmacy.

H3 Upon the completion of the pharmacy course, a Diploma in Pharmacy was awarded to the students. In 1958, The Maritime College of Pharmacy requested that the Canadian Conference of Pharmaceutical Faculties appoint a committee to assess pharmaceutical education in the Maritimes and make recommendations for the development of the College of Pharmacy. In 1959, the committee submitted a comprehensive report on pharmaceutical education in the Maritimes. A summary of some of their recommendations is as follows:

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The first training in pharmacy in Nova Scotia

College of Pharmacy

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Groups or divisions which may be added to take care of

The University, and also to include any other para-medical

been approved by the Board of Governors and the Senate of

of Physiotherapy and Occupational Therapy which have already

of Pharmacy, the School of Nursing, and the proposed College



1. That the course of study in the Maritime College of Pharmacy and Dalhousie University be brought into conformity with the minimum requirements of the Canadian Conference of Pharmaceutical Faculties, that is, by instituting a four-year curriculum based upon senior matriculation or the equivalent and leading to a Bachelor's degree, preferably a Bachelor of Science in Pharmacy.
2. That negotiations with Dalhousie University be initiated by the Maritime College of Pharmacy with a view to the University establishing a Faculty of Pharmacy.
3. That provision be made for adequate staff who hold advanced degrees in Pharmacy.
4. That adequate facilities be provided for the College of Pharmacy.

H4 At the present time, the following steps have been taken to implement the recommendations of the committee. The Maritime College of Pharmacy has been incorporated into Dalhousie University as a College of Pharmacy in the Faculty of Health Professions (and Dr. J. G. Duff has been appointed Director of the College of Pharmacy). This fall the first year of a new four-year degree course based on Junior matriculation was introduced.

H5 There are still many problems to be solved before the recommendations of the Advisory Committee can be completely fulfilled. The Maritime College of Pharmacy was by the pharmacists of the Maritime region in affiliation with Dalhousie University and received some financial

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There are still many problems to be solved

before the recommendations of the Advisory Committee can be

completely fulfilled. The Maritime College of Pharmacy was

with Dalhousie University and received some financial



1 assistance from the provincial and federal governments. In
2 order to implement the recommendations of the committee so
3 that pharmaceutical education in the Maritimes will meet the
4 standards obtaining elsewhere in Canada, further sources
5 of financial support must be found. Additional qualified staff
6 must be recruited, and expanded and improved facilities with
7 modern equipment must be provided. Since Dalhousie University
8 has agreed to provide for the training of Pharmacists, a
9 financial strain has been placed on the University.

10 H6 The committee recommended that in order to
11 meet the needs of the Maritime region, the College of Pharmacy
12 should be prepared to handle approximately 110 students. In
13 1960-1961, the enrolment at the College was 51. This year
14 78 students are enrolled in the College of Pharmacy and un-
15 less expanded facilities are available next year, it may be-
16 come necessary to limit the number of admissions.

17 H7 The pharmacists of the Maritimes are contri-
18 buting to the operation of the College, but it is probably
19 neither reasonable nor realistic to expect that they will
20 increase their contributions much beyond their present
21 commitments for the operation of the College of Pharmacy.
22 Certainly the increased costs which will be incurred in meet-
23 ing the estimated requirements of the future cannot be met
24 from this source. It is estimated that the expenditures for
25 1961-1962 will be approximately \$30,000.00. The pharmacists
26 of the Maritimes are contributing approximately 30% of this
27 sum at the present time. Endowment income from the assets of
28 the Maritime College of Pharmacy, which have been transferred
29 to Dalhousie University, is providing approximately 13%.
30 The remaining income for the operation of the College must



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of financial support must be found. Additional qualified staff

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from this source. It is estimated that the expenditures for

1961-1962 will be approximately \$30,000.00. The pharmacists

of the Maritimes are contributing approximately 20% of this

at the present time. Estimated income from the assets of

the Maritime College of Pharmacy, which have been transferred

to Dalhousie University, is providing approximately 13%.

The remaining income for the operation of the College must



1 be provided by student fees, from the general funds of Dal-
2 housie University and from provincial and federal grants.

3 H8 When the required facilities and staff are
4 provided, it is estimated that the expenditures for the college
5 will be approximately \$65,000.00. It is hoped that the prov-
6 incial and federal governments will provide the necessary
7 financial assistance to the College so that the recommendat-
8 ions of the committee can be completely fulfilled and that
9 adequate pharmaceutical training will be provided for the
10 Maritime provinces.

11 H9 A more comprehensive Report on Pharmaceutical
12 Education will be presented at a later date to the commission
13 by the Canadian Conference of Pharmaceutical Faculties.
14 Other aspects of Pharmacy are being presented by the Provin-
15 cial societies and associations throughout Canada, and the
16 information in these briefs pertaining to the educational
17 aspects of pharmacy also applies to the Maritime region.

18 School of Nursing

19 H10 The School of Nursing at Dalhousie University
20 was organized in 1949. A five-year basic programme in nursing
21 and a one-year programme for graduate nurses were offered
22 leading to the degree of Bachelor of Nursing Science and
23 to the diploma in Public Health Nursing or in Teaching and
24 Supervision in Schools of Nursing.

25 H11 In 1958, the basic programme was reorganized
26 and extended and the degree renamed Bachelor of Nursing. The
27 changes included the addition of professional material to
28 provide the student not only with a basic liberal arts
29 education but also a first level professional qualification
30 in public health nursing or in teaching in schools of nur-
sing.

be provided by student fees, from the general funds of Dalhousie University and from provincial and federal grants. When the required facilities and staff are

will be approximately \$65,000.00. It is hoped that the prov

financial assistance to the College so that the recommendations of the committee can be completely fulfilled and that adequate pharmaceutical training will be provided for the

A more comprehensive Report on Pharmaceutics Education will be presented at a later date to the commission by the Canadian Conference of Pharmaceutical Faculties.

Other aspects of Pharmacy are being presented by the Provincial societies and associations throughout Canada, and the information in these briefs pertaining to the educational aspects of pharmacy also applies to the Maritime region.

School of Nursing

The School of Nursing at Dalhousie University

was organized in 1949. A five-year basic programme in nursing

and a one-year programme for graduate nurses were offered

leading to the degree of Bachelor of Nursing Science and

to the diploma in Public Health Nursing or in Teaching and

Supervision in Schools of Nursing.

In 1958, the basic programme was reorganized

and extended and the degree renamed Bachelor of Nursing. The

changes included the addition of professional material to

provide the student not only with a basic liberal arts

education but also a first level professional qualification

in public health nursing or in teaching in schools of nursing.



H12 The responsibilities and functions of the professional nurse in schools of nursing, hospitals and public health agencies have been greatly affected by the rapid changes and advances in the fields of medical and social services. These changes create a demand for better prepared and specially qualified nurses for teaching, supervisory and administrative posts, as well as for general nursing posts in hospitals and public health agencies. The need for personnel with specialized training for these positions is very acute. To help meet this need, one-year Diploma courses for graduate nurses have been made possible through Federal Health Grants administered by the Provincial Governments of Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland. We are at present conducting courses in three fields, namely:

1. Nursing Service Administration
2. Public Health Nursing
3. Teaching in Schools of Nursing

H13 There is considerable interest locally in short-term courses for which no credit is offered-- these are variously referred to as refresher of certificate courses and vary in length from three days to five weeks. The demand for these short-term programmes, we feel, will continue to be reasonably steady and is a service which the University School endeavours to provide to the community.

H14 As noted in Paragraph H12, these courses have supported by funds from the Federal Health Grants administered through the four Atlantic Provinces. Should there be any change in the nature of this support (for example, if one or more of the provinces should discontinue participation

The responsibilities and functions of the

professional nurse in schools of nursing, hospitals and

public health agencies have been greatly affected by the rapid

changes and advances in the fields of medical and social

services. These changes create a demand for better prepared

and specially qualified nurses for teaching, supervisory and

administrative positions in the medical and nursing fields.

It is the purpose of this report to present a summary of the

present situation and to suggest some possible solutions.

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for graduate nurses have been made possible through Federal

Health Grants administered by the Provincial Governments of

Nova Scotia, New Brunswick, Prince Edward Island and

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courses and vary in length from three days to five weeks.

The demand for these short-term programmes, we feel, will

continue to be reasonably steady and as a service which is

University School endeavours to provide to the community.

1114 As noted in Paragraph 1113, these courses

have supported by funds from the Federal Health Grants and

any change in the nature of this support (for example, if

one or more of the provinces should discontinue participation



1 in the programme), this would necessitate a reappraisal of
2 the whole basis of financial support of the School of Nur-
3 sing and would make imperative the provision of funds from
4 other sources to enable the School to continue to render
5 these important services.

6 H15 As has been noted in various surveys 1, 2
7 conducted over the past ten years, there is a very urgent
8 need for more nurses in Nova Scotia. An estimate of re-
9 quired numbers of personnel based on recommended standards
10 shows the need to be approximately 1200 additional staff.
11 This need ought to be met as soon as possible and certainly
12 within the next five or six years. A fraction of this num-
13 ber may well be supplied from the auxiliary personnel group,
14 but it is doubtful if more than 400 of this category could
15 become available before 1965, and therefore the number of
16 professional nurses required would rest at 800, which is
17 far above the numbers which the present schools of nursing
18 could train in this period.

19 1. Report on the Survey of Nursing Facilities and Nur-
20 sing Education Needs in Nova Scotia under the Fede-
21 ral Health Survey Grant, 1950, E. MacLennan.

22 2. Survey of Nursing Services and Requirements in
23 Nova Scotia Hospitals 1956 with Revisions 1959,
24 F. Gass.

25
26
27
28
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30
(These are Government documents and are out of
print.)

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Nova Scotia Hospitals 1956 with Revisions 1959.

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1 H16 In the face of this acute shortage it is
2 imperative that additional facilities for the preparation
3 of the professional nurse be developed. A slight increase
4 in the capacity of the existing schools of nursing can be
5 anticipated in view of the hospital construction programme
6 now being carried out in our province. Another possible
7 solution to the problem of overcoming this shortage of
8 nurses might be found in the Central School Plan of nur-
9 sing education which perhaps might be undertaken as an ex-
10 periment in nursing education in Nova Scotia. By definition,
11 "a Central School is one whose administrative and education-
12 al personnel are organized so as to constitute an educa-
13 tional entity although the students' clinical experience
14 is secured in more than one hospital and in other agencies
15 as well". The proposed pattern of regional hospitals with
16 teaching staff for medical school needs would appear to
17 provide a ready-made clinical field for nursing education
18 as well. The many details of finance, administration, re-
19 cruitment, and so forth, require considerable thought and
20 careful planning, but the general principles underlying
21 the Central School Plan would seem to be readily applicable
22 to the geographical distribution of hospitals in Nova
23 Scotia. Should any such plan prove feasible in Nova Scotia,
24 it could certainly count on the full support not only of
25 the Dalhousie School of Nursing but on the other faculties
26 of the university which might properly be called upon to
27 give assistance as well.

28 H17 The proposal tentatively put forth in para-
29 graph H16 would not involve at this time the discontinuance
30 of the existing Schools of Nursing in the province.



1 In the face of this acute shortage it is
2 imperative that additional facilities for the preparation
3 of the professional nurse be developed. A slight increase
4 in the capacity of the existing schools of nursing can be
5 anticipated in view of the hospital construction programme
6 now being carried out in our province. Another possible
7 solution to the problem of overcoming this shortage of
8 nurses might be found in the General School Plan of nursing
9 education which perhaps might be undertaken as an experiment
10 in nursing education in Nova Scotia. By definition
11 "a General School is one whose administrative and educational
12 personnel are organized so as to constitute an educational
13 entity although the students' clinical experience
14 is secured in more than one hospital and in other agencies
15 as well". The proposed pattern of regional hospitals with
16 nursing units would provide a ready-made clinical field for nursing education
17 as well. The many details of finance, administration, recruitment, and so forth, require considerable thought and
18 careful planning, but the general principles underlying
19 the General School Plan would seem to be readily applicable
20 to the geographical distribution of hospitals in Nova
21 Scotia. Should any such plan prove feasible in Nova Scotia,
22 it could certainly count on the full support not only of
23 the Dalhousie School of Nursing but on the other faculties
24 of the university which might properly be called upon to
25 give assistance as well.

26 The proposal tentatively put forth in paragraph H16 would not involve at this time the discontinuance
27 of the existing Schools of Nursing in the province.



H18 In order to develop and expand the facilities for nursing education, to the extent referred to in paragraph H15, financial assistance beyond the resources of the local area will be required. The following recommendations are put forward in support of the request for such assistance:

(A) That the several levels of Government (federal, provincial, and municipal) ought to accept responsibility on an established and recognized basis for the support of adequate educational programmes in nursing and that financial assistance be assured through the various channels appropriate to the respective levels of government, such as professional training grants, grants offered under Vocational Training Plans and direct assistance for a sound nursing educational programme.

(B) That the relevant governments concerned ought to make provision for the continuance on an assured basis of professional training grants for the preparation of administrators, supervisors, instructors for hospitals, schools of nursing and public health nursing agencies.

H18

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(B) That the relevant governments concerned ought to make

provision for the continuance on an assured basis of pro-

fessional training grants for the preparation of adminis-

trators, supervisors, instructors for hospitals, schools

of nursing and public health nursing agencies.



APPENDIX B

DALHOUSIE MEDICAL SCHOOL BUILDINGS

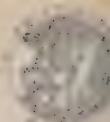
AND AFFILIATED HOSPITALS

B-1 Forrest Building

The Forrest Building, built in 1886, is shared by the Department of Biology of the Faculty of Arts & Science and the Departments of Anatomy and Microanatomy of the Faculty of Medicine. The Departments of Surgery and Physiology also have research laboratories in this building. In recent years as the Faculty of Law, the Faculty of Dentistry and the International Fisheries Research Commission moved from this Building, the Department of Biology and the Medical School departments have expanded. The attic was also converted to use. This Topsy-like growth has resulted in a "sandwich" with Biology on the top floor, Anatomy next on the third floor, Biology again on the second floor, Anatomy on the first floor, together with research laboratories for Surgery and in the basement various service rooms and student quarters for both Faculties, and a research laboratory for Physiology. The arrangement is very inefficient.

An even greater disadvantage is the large amount of waste space in the wide, high-ceilinged corridors, excessively large offices, etc. Barely 50% of the floor area of this building can be effectively used. The great fire hazard and the inadequacy of the water, sewage and electrical systems are other factors which limit the usefulness of this building and make remodeling extremely expensive.

Nevertheless, it is likely that it will have to be used for the next 20 or 30 years until a plateau is



APPENDIX B

ALLEGEDLY DEFECTIVE BUILDING

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Porter Building

B-1

The Porter Building, built in 1886, is shared by the Department of Biology of the Faculty of Arts & Sciences and the Department of Geology and Mineralogy of the Faculty of Medicine. The Department of Geology and Mineralogy also have several laboratories in this building. In recent years the Department of Geology and Mineralogy and the Department of Biology have been moving from this building. The Department of Geology and Mineralogy School departments have expanded. The building was also converted to use. This three-story building was originally a "sanatorium" with living on the top floor, sleeping on the middle floor, and dining on the bottom floor. Now on the first floor, together with several laboratories for Biology and in the basement, various storage rooms and student meetings the first floor, and a research laboratory for the Biology. The expansion is very limited. An even greater disadvantage in the large amount of waste space in the building, especially in the excessively large offices, etc. Barely 50% of the floor area of this building can be effectively used. The present plan and the expansion of the building will be a serious handicap to the Faculty of Medicine and the Faculty of Arts & Sciences. Usefulness of this building and make remodeling extremely expensive. Nevertheless, it is likely that it will have to be used for the next 20 or 30 years until a plan can be



1 reached in expansion of the University, which will allow
2 replacement as well as additions to the plant. The present
3 plan is to obtain a new Medical Science Building to which
4 the Departments of Anatomy and Microanatomy will move,
5 leaving the Forrest Building to the Department of Biology
6 to take care of rapidly increasing enrolment and to pro-
7 vide necessary research facilities for Biology and the
8 Institute of Oceanography.

9
10 Medical Sciences Building. Constructed in
11 1922-23, this building houses the Departments of Physio-
12 logic, Pharmacology and Biochemistry. Designed for 60 medi-
13 cal and dental students with one professor in each of the
14 three subjects it now serves 85 medical and dental students
15 as well as science students and those of the para-medical
16 professions, and a staff of eleven teachers, as well as
17 research fellows and technicians. Because of this crowd-
18 ing, the Board of Governors has approved the provision of
19 a new medical building for these departments and Anatomy
20 and Microanatomy, if funds can be obtained. The present
21 Medical Sciences Building will be remodeled to serve the
22 needs of the Faculty of Health Professions (Nursing, Phar-
23 macy, Physiotherapy and Occupational Therapy).

24 Public Health Clinic This building houses
25 out-patient clinics for children and prenatal patients but
26 it is anticipated that these hospital services will be
27 moved to the Grace Maternity Hospital now under construc-
28 tion and the Children's Hospital when a new building is
29 provided. The Clinic Building will then be required for
30 the research laboratories of the clinical departments,

reached in expansion of the University, which will allow replacement as well as additions to the plant. The present plan is to obtain a new Medical Science Building to which the Departments of Anatomy and Microanatomy will move, leaving the Forensic Building to the Department of Biology to take care of rapidly increasing enrollment and to provide necessary research facilities for Biology and the Institute of Oceanography.

Medical Sciences Building. Constructed in 1922-23, this building houses the Departments of Physiology and Biochemistry. It is a three-story building, each of the three subjects it now serves 85 medical and dental students as well as science students and those of the para-medical professions, and a staff of eleven researches, as well as research fellows and technicians. Because of this crowding, the Board of Governors has approved the provision of a new medical building for these departments and Anatomy and Microanatomy. If funds can be obtained. The present Medical Sciences Building will be remodeled to serve the needs of the Faculty of Health Professions (Nursing, Pharmacy, and Dietetics).

It is anticipated that these hospital services will be moved to the Grace Memorial Hospital now under construction and the Children's Hospital when a new building is provided. The Clinic Building will then be required for the research laboratories of the clinical departments.



1 Medicine, Surgery, Obstetrics, Paediatrics, Psychiatry
2 and the other medical and surgical specialties.

3 Pathology Institute. The Provincial Depart-
4 ment of Public Health provides space for the University
5 departments of Pathology and Bacteriology in the Pathology
6 Institute. This was also constructed in 1923, but a large
7 new addition was completed in 1961 with excellent teaching
8 laboratories, lecture rooms and seminar rooms for the
9 Departments of Pathology and Bacteriology. The old section
10 of the building formerly used for teaching is being re-
11 designed as research laboratories.

12
13 Library. The Medical-Dental Library Build-
14 ing was opened in 1939. It is an excellent structure, but
15 is already becoming over-crowded. In the planning for a
16 new Medical Building provision for larger library and
17 reading room facilities will be necessary.

18 Teaching Hospitals. The Clinical Departments
19 have in former years carried out most of their work in the
20 affiliated hospitals, the Victoria General, Camp Hill,
21 Children's, Grace Maternity and the Nova Scotia Rehabilit-
22 ation Centre. During the last five years, some very neces-
23 sary research facilities have been provided for these
24 departments in the Dalhousie Public Health Clinic.

25 Almost all of the affiliated teaching hos-
26 pitals have plans for large new additions. The Victoria
27 General Hospital will have a capacity of 850 beds. The
28 Grace Maternity is building a new hospital of 110 beds.
29 The Children's Hospital will probably have a new building
30 within the next five years of approximately 250 beds,

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Department of Public Health provides space for the University departments of Pathology and Bacteriology in the Pathology Institute. This was also constructed in 1923, but a large new addition was completed in 1961 with excellent research laboratories, lecture rooms and seminar rooms for the Departments of Pathology and Bacteriology. The old section of the building formerly used for teaching is being redesigned as research laboratories.

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1 replacing its present structure of 150 beds. The Nova
2 Scotia Rehabilitation Center plans a new building of 50
3 beds with a large out-patient unit. Camp Hill has a capa-
4 city of 550 beds, and the Armed Forces Hospital 200. The
5 Halifax Infirmary is just completing a new addition, bring-
6 ing its capacity to 480 beds. There is a great need for
7 more beds in the Halifax Convalescent Hospital, now 50 beds,
8 which is housed in the former Tuberculosis Hospital Build-
9 ing. When the Rehabilitation Centre moves to a new build-
10 ing, the Convalescent Hospital will have approximately 130
11 beds against a need of approximately 350.

12 These hospitals will have a total bed capa-
13 city of approximately 2600 beds by 1965. It must be em-
14 phasized however, that not all are available for teaching.
15 It has been recommended by the Association of Canadian
16 Medical Colleges that the general hospitals used for
17 teaching medical students (excluding military and veterans'
18 hospitals) should have a minimum of 10 teaching beds per
19 fourth year student. The present plans at Dalhousie are
20 for a building to accommodate 75 first year medical students
21 as the desirable number, but provision will be made to
22 permit enrolment up to 100 if necessary. The teaching
23 units in the affiliated hospitals will contain approximately
24 750 beds by 1965, sufficient to graduate 75 medical students
25 per year. These teaching facilities will be adequate pro-
26 vided that any future plan for the development of medical
27 services insurance retains the closed teaching wards now
28 available or planned in future construction.
29
30

replacing its present structure of 150 beds. The Nova Scotia Rehabilitation Center plans a new building of 50 beds with a large out-patient unit. Camp Hill has a capacity of 250 beds, and the Armed Forces Hospital 200. The Halifax Infirmary is just completing a new addition, bringing its capacity to 480 beds. There is a great need for more beds in the Halifax Convalescent Hospital, now 50 beds which is housed in the former Tuberculosis Hospital Building. When the Rehabilitation Center moves to a new building, the Convalescent Hospital will have approximately 150 beds against a need of approximately 250.

These hospitals will have a total bed capacity of approximately 2600 beds by 1965. It must be emphasized however, that not all are available for teaching. It has been recommended by the Association of Canadian Medical Colleges that the general hospitals used for teaching medical students (excluding military and veterans hospitals) should have a minimum of 10 teaching beds per fourth year student. The present plans at Dalhousie are for a building to accommodate 75 first year medical students as the desirable number, but provision will be made to permit enrolment up to 100 if necessary. The teaching services insurance retains the closed teaching wards now available or planned in future construction.

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APPENDIX C

The Victoria General Hospital,
Halifax N.S.
October Fourth, 1961.

The Dean, Faculty of Medicine
Dalhousie University
Halifax, Nova Scotia

Dear Doctor Stewart:

ROYAL COMMISSION ON MEDICAL SERVICES

At its last meeting, September 27, 1961, the
Board of Commissioners of the Victoria General Hospital
passed the following resolution.

"THAT, UNDER ANY FORM OF UNIVERSAL MEDICAL
CARE PROGRAM, THE TEACHING ASPECTS AND RE-
SPONSIBILITIES OF HOSPITALS BE PROTECTED AND
MAINTAINED AT EXISTING OR IMPROVED STANDARDS.
THIS RESOLUTION IS TO BE FORWARDED TO THE DEAN
OF MEDICINE, WITH THE REQUEST THAT IT BE IN-
CLUDED IN THE UNIVERSITY BRIEF ON EDUCATION."

In the development of medical education in this
country, the system of "graded responsibility for patient
care under supervision" has come to be the accepted pattern
of teaching in the clinical years and can now be regarded
as essential to the operation of a teaching hospital.

In keeping with the foregoing, the Victoria General
Hospital Board of Commissioners subscribes to the philoso-
phy embodied in the definition of a teaching unit as adopt-
ed by the Canadian Medical Association.

A teaching unit is a hospital or a group of
beds in a designated area of a hospital in which the care
of the patient is the function of the team of staff
physician-resident-interne-clinical clerk. The medical



The Victoria General Hospital
Halifax N.S.

The Dean, Faculty of Medicine
Dalhousie University

Dear Doctor Stewart:

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country, the system of "graded responsibility for patient
care under supervision" has come to be the accepted pattern
of teaching in the clinical years and can now be regarded
as essential to the operation of a teaching hospital.

In keeping with the foregoing, the Victoria General
Hospital Board of Commissioners endorses to the fullest
the definition of a teaching unit as adopted
by the Canadian Medical Association

A teaching unit is a hospital or a group of
beds in a designated area of a hospital in which the care
of the patient is the function of the team of staff



1 staff of such a teaching unit is to be appointed jointly
2 by University and Hospital and organized as departments,
3 the heads of which are similarly jointly appointed by
4 University and Hospital.

5 A teaching patient is one who enters a teach-
6 ing unit, but patients in other parts of a hospital with
7 a teaching unit may be used for teaching with the consent
8 of the patient and attending physician.

9 In addition to the foregoing, there are many
10 additional requirements for a Teaching Hospital. These
11 include the education of nurses and nurses aides, techni-
12 cians, etc., and adequate space, teaching and demonstration
13 rooms, conference rooms, laboratories, etc. far in excess
14 of those required for a non-teaching hospital. For a
15 teaching hospital to meet its responsibilities as such,
16 there must be special investigation and clinical research
17 facilities involving special nursing units, laboratories
18 and much highly specialized investigative and treatment
19 equipment.

20 It must also be recognized and accepted that
21 the operating costs of such a teaching hospital will be
22 considerably higher than those of a non-teaching institu-
23 tion.

24
25 Yours very truly,

26
27 C.M. Bethune, M.D.

28 Administrator
29
30

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It must also be recognized and accepted that

the operating costs of such a teaching hospital will be

considerably higher than those of a non-teaching institution.

tion.

Yours very truly,

C.M. Bethune, M.D.



APPENDIX D

Number of students from the Atlantic
Provinces enrolled in First Year Medicine at Canadian
Medical Schools, 1951 to 1961 inclusive.

YEAR	UNIVERSITY	STUDENTS ADMITTED FROM				TOTAL	% AT DALHOUSIE	
		N.S.	N.B.	NFLD	PEI		TOTAL ENGLISH	SPEAKING
1951	Dalhousie	28	15	7	8	58	82.8	82.8
	French Canadian	-	-	-	-	-	-	-
	Other English Canadian	2	7	-	3	12		
1952	Dalhousie	28	11	8	9	56	83.6	91.8
	French	1	4	0	1	6		
	Other English	-	5	0	0	5		
1953	Dalhousie	21	10	13	4	48	72.9	85.7
	French	-	10	0	0	10		
	Other English	2	6	-	-	8		
1954	Dalhousie	17	13	6	8	44	81.5	81.5
	French	0	-	-	0	4		
	Other English	4	5	-	1	10		
1955	Dalhousie	26	9	15	4	54	87.	88.5
	French	-	1	0	0	1		
	Other English	-	7	-	-	7		
1956	Dalhousie	23	10	3	7	43	79.6	86.
	French	1	3	-	-	4		
	Other English	-	5	1	1	7		
1957	Dalhousie	27	14	6	7	54	84.3	91.5
	French	1	4	-	-	5		
	Other English	1	3	1	-	5		
1958	Dalhousie	28	7	4	5	44	83.	91.6
	French	1	4	-	-	5		
	Other English	1	2	1	-	4		
1959	Dalhousie	15	9	8	6	38	79.2	82.6
	French	1	1	-	-	2		
	Other English	-	5	3	-	8		
1960	Dalhousie	18	8	8	8	42	79.2	82.3
	French	1	1	-	-	2		
	Other English	-	5	4	-	9		
Total	Dalhousie					481	81.3	86.3
	French Canadian					35		
	Other English Canadian					75		

591

Dalhousie - Students from the Atlantic Provinces attending
Dalhousie University Medical School.

French - French speaking students from the Atlantic
Provinces attending other Canadian Medical Schools.

Cont'd.



Other English - English-speaking students from the
Atlantic Provinces attending other
Canadian Medical Schools.

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APPENDIX E.

In the Survey of Health Facilities and Services in Nova Scotia under the Federal Health Survey Grant in 1949-50, the following table showed the proportion of doctors starting practice in each ten year period who were Dalhousie graduates. An attempt is being made to obtain comparable data from all provinces for 1951 to 1960.

TABLE I.

UNIVERSITY AND YEAR OF GRADUATION OF PHYSICIANS
IN FOUR ATLANTIC PROVINCES. 1950.

University	Year of Graduation-						
	Before 1891	1891-1900	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950
Dalhousie	-	9	33	52	116	132	222
McGill	2	14	49	34	59	49	36
Toronto	1	1	7	3	8	10	9
Queens	-	2	1	11	7	9	7
Laval	-	-	4	8	12	15	24
Montreal	-	-	-	1	2	5	4
Other Can.	-	2	1	-	2	5	1
U.K.	3	1	4	4	18	37	40
U.S.A.	2	11	11	13	6	5	2
Other	-	-	-	1	5	6	3
Total No.	8	40	110	127	235	273	338
Per cent							
Dalhousie	0	22	30	41	49	48	66

Total-
564.

233

39

Cont'd.

APPENDIX E.

IN THE HISTORY OF MEDICAL EDUCATION AND RESEARCH

Alies in Nova Scotia under the Federal Health Survey Grant in 1949-50, the following table shows the proportion of doctors accepting practice in each year period who were Dalhousie graduates. An attempt is being made to obtain comparable data from all provinces for 1951 to 1955.

TABLE 1.

UNIVERSITY AND YEAR OF GRADUATION OF PHYSICIANS

Year of Graduation

University	1891	1903	1910	1920	1930	1940	1950
Dalhousie	-	9	33	52	116	140	242
Toronto	1	1	7	3	8	10	3
Queens	-	2	1	11	7	9	7
Laval	-	-	4	8	12	15	44
Montreal	-	-	-	1	2	5	4
Other Can.	-	2	1	-	2	3	1
U.K.	3	1	1	4	18	27	40
U.S.A.	2	11	11	13	3	5	2
Other	-	-	-	1	2	6	3
Total No.	8	40	110	127	212	273	187
Dalhousie	0	22	30	41	44	48	100

Total-



Total Cont'd.

Queens	37	-
Laval	63	-
Montreal	12	-
Other Can.	11	-
U.K.	107	-
U.S.A.	50	-
Other	15	-
Total No.	1131	-
Percent		-
	50	-
Dalhousie		-

It is to be noted that 50% of all practising physicians in the four provinces were Dalhousie graduates as were 66% of the doctors who started practice in the 1941 to 1950 period. It is estimated that this proportion is not over 70 per cent.

The following table shows the total number of Dalhousie graduates from 1891 to 1950 and the proportion who were practising in the Atlantic Provinces at the time of the 1949-50 survey.

TABLE 2

NUMBER OF DALHOUSIE MEDICAL GRADUATES 1891 to 1950
BY TEN YEAR PERIODS, AND PROPORTION PRACTISING IN
ATLANTIC PROVINCES IN 1950

Year of Graduation	Total Dalhousie Graduates	In Atlantic Provinces.	Per cent.
1891-1900	74	9	21.6
1901-1910	127	33	26.0
1911-1920	110	52	47.3
1921-1930	256	116	48.3

Cont'd.

1891-1900	71	2
1901-1910	127	30
1911-1920	110	32
1921-1930	283	118
Other	15	-
U.S.A.	50	-
U.K.	107	-
Other Can.	11	-
Total No.	1131	-
Percent	50	-
Dalhousie	-	-

It is to be noted that 50% of all practicing physicians in the four provinces were Dalhousie graduates as were 66% of the doctors who assisted practice in 1941 to 1950 period. It is estimated that this proportion is not over 70 per cent.

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TABLE 2

NUMBER OF DALHOUSIE MEDICAL GRADUATES 1891 TO 1950 BY TEN YEAR PERIODS, AND PROPORTION PRACTISING IN ATLANTIC PROVINCES IN 1950

Year of Graduation	Total Dalhousie	In Atlantic Provinces	Per cent
1891-1900	71	2	
1901-1910	127	30	
1911-1920	110	32	
1921-1930	283	118	

Table 2, Cont'd.

Year of Graduation	Total Dalhousie Graduates	In Atlantic Provinces.	Per cent.
1931-1940	298	132	44.3
1941-1950	382	222	58.1

It is emphasized that the small proportions in the two earlier decades is heavily influenced by the reduction of the graduates through death. The proportion of graduates between 1941 and 1950 who stayed in the Atlantic Provinces was 58.1.

The following table shows that 52.1 per cent of the graduates between 1951 and 1960 are practising in this region and an additional 24.2 per cent are still in post-graduate study. Some of these will return to practice here. It is estimated that this will bring the proportion to approximately 60 per cent.

TABLE 3.

DALHOUSIE MEDICAL GRADUATES 1951 to 1960 BY
LOCATION OF PRACTICE INCLUDING POST GRADUATE STUDENTS.

YEAR	N.S.	N.B.	P.E.I.	NFLD.	Other	P.G.	TOTAL
1951	23	5	3	4	20	0	55
1952	25	3	0	2	17	6	53
1953	20	8	5	1	13	9	56
1954	16	6	2	2	13	15	54
1955	12	6	2	2	7	19	48
1956	14	10	3	3	6	15	51
1957	15	7	2	3	13	9	49
1958	7	3	3	8	17	17	56
1959	11	8	4	3	12	14	52
1960	13	5	1	3	5	23	50
Total	156	61	25	31	123	127	524

Table 2, Cont'd.

Year of Graduation Total Dalhousie In Atlantic
Graduates Provinces Per cent

1941-1950 332 222 58.1

It is emphasized that the small proportions in the two earlier decades is heavily influenced by the question of the graduates through death. The proportion of graduates between 1941 and 1950 who stayed in the Atlantic Provinces was 58.1.

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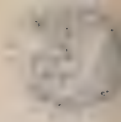
DALHOUSIE MEDICAL GRADUATES 1941 to 1950 BY LOCATION OF PRACTICE INCLUDING POST GRADUATE STUDENTS

YEAR	N.S.	N.B.	P.E.I.	NEWF.	Other	P.A.	TOTAL
1941-1950	23	5	3	4	20	0	55
1941-1950	25	3	0	2	17	6	53
1941-1950	20	8	5	1	13	9	56
1941-1950	16	6	2	2	13	15	54
1941-1950	12	6	2	2	7	19	48
1941-1950	14	10	3	3	6	15	51
1941-1950	15	7	2	3	13	0	40
1941-1950	7	7	7	7	7	7	52
1941-1950	11	8	4	3	12	14	52
1941-1950	13	5	1	3	5	23	50
1941-1950	156	61	25	31	123	187	584



1 Total in Atlantic Provinces 273. Per cent in Atlantic
2 Provinces 52.1%. Per cent still in Post-Graduate Study
3 24.2%.

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Total in Atlantic Provinces 273. Per cent in Atlantic

27.3 per cent in Atlantic Provinces

27.3



APPENDIX F

ESTIMATES OF THE REQUIREMENT OF PHYSICIANS

IN THE ATLANTIC PROVINCES

1. The ratio of population per physician is less favourable in the Atlantic Provinces than in the rest of Canada. The number of active resident physicians in the four provinces is 1528. This is a ration of 1246 persons per doctor as compared with the Canadian average of 879. There is a greater shortage of physicians in Newfoundland than in the other three provinces. The ratio in the three Maritime provinces is 1151 persons per physician.

2. Table 1 shows the ratio of population per physician in Canada and in the three Maritime Provinces from 1911 to 1960, at ten year intervals and for the four Atlantic Provinces in 1951 and 1960.

TABLE 1

<u>YEAR</u>	<u>RATIO OF POPULATION PER PHYSICIAN</u>		
	<u>Canada</u>	<u>Three Maritime Provinces</u>	<u>Four Atlantic Provinces</u>
1911	970	1232	
1921	1108	1261	
1931	1034	1299	
1941	968	1248	
1951	977	1271	1406
1960	879	1151	1246
1960			
Population	18,034,443	1,439,446	1,905,360
1960			
Physicians	20,517	1,251	1,528

favourable in the Atlantic Provinces than in the rest of Canada. The number of active resident physicians in the four provinces is 1528. This is a ratio of 1246 persons per doctor as compared with the Canadian average of 879. There is a greater shortage of physicians in Newfoundland than in the other three provinces. The ratio in the three Maritime provinces is 1171 persons per physician.

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YEAR	RATIO OF POPULATION PER PHYSICIAN		
	Canada	Three Maritime Provinces	Four Atlantic Provinces
1911	970	1932	
1921	1108	1951	
1931	1034	1959	
1941	968	1946	
1951	977	1971	1465
1960	879	1951	1485
1960			
Population 18,034,413			
Physicians 20,517			
1,361			
1,001,360			



1 This shows that there was a very stable rate
2 from 1911 to 1951 both in Canada and the three Maritime
3 Provinces. In view of the fact tht there are so many more
4 doctors who are engaged in other activities than in the
5 direct care of patients in recent years, it might be ex-
6 pected that a better ratio would be necessary than in 1911.
7 However, to counteract this there has been an improvement
8 in transportation which permits a doctor to take care of
9 more patients than formerly. In any event, this table in-
10 dicates that it has only been during the last decade that
11 the ratio of population per physician has been improved in
12 Canada as a whole, and that the same trend occurred in the
13 Atlantic Regio.

14 3. Without suggesting that the ratio of popula-
15 tion per physician in Canada is ideal, it is interesting to
16 calculate how many additional physicians would be required
17 in this region to meet at least that ratio. Using the Do-
18 minion Bureau of Statistics' estimate of the population of
19 Canada and of the provinces as of June 1st, 1960, and ap-
20 plying the ratio of 879 persons per physician, it is es-
21 timated that the three Atlantic Provinces should have 1590
22 physicians as compared with the present supply of 1251, a
23 shortage of 339. Including Newfoundland, the four Atlantic
24 Provinces would require 2109 physicians to meet the Cana-
25 dian ratio, as against the present number of 1528, a
26 shortage of 581.

27 4. The report of the Survey of Health Facilities
28 and Services in Nova Scotia in 1949-1950 contained several
29 estimates of the requirements for medical and dental per-
30 sonnel based on different standards. The methods of

This shows that there was a very stable rate

from 1911 to 1951 both in Canada and the three Maritime
Provinces. In view of the fact that there are so many more
doctors who are engaged in other activities than in the
direct care of patients in recent years, it might be ex-
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the ratio of population per physician has been improved in
Canada as a whole, and that the same trend occurred in the
Atlantic Region.

3. Without suggesting that the ratio of popula-
tion per physician in Canada is ideal, it is interesting to
calculate how many additional physicians would be required
in this region to meet at least that ratio. Using the De-
partment of Statistics' estimate of the population of
Canada and of the provinces as of June 1st, 1960, and ap-
plying the ratio of 372 persons per physician, it is es-
timated that the three Atlantic Provinces should have 1900
physicians as compared with the present supply of 1871, a
shortage of 29. Including Newfoundland, the four Atlantic
provinces would require 2907 physicians to meet the stan-
dard ratio, as against the present number of 1987, a
shortage of 920.

4. The report of the Survey of Health Facilities
and Services in Nova Scotia for 1955-1959 contained certain
estimates of the requirements for medical and dental per-
sonnel based on different standards. The ratios of



1 estimating requirements have not improved greatly since
2 that time, although some of the data should be revised to
3 cover the last decade. It is planned to obtain additional
4 information from the Provincial Medical Boards of the other
5 three Atlantic Provinces to augment the data now being
6 collected by the Medical Society of Nova Scotia. This will
7 provide a more accurate estimate of the physicians required
8 in the area.

9 5. The above report made another approach toward
10 estimating the adequacy of the supply of physicians. The
11 following table showed the ratio of population per general
12 practitioner specialist in Canada in 1941 by community
13 size. No later studies are available, to our knowledge,
14 which relate the number of physicians by tupe of practice
15 to the community size.

16
17 TABLE 2

18 RATIO OF POPULATION PER GENERAL PRACTITIONER
19 AND SPECIALIST IN CANADA BY COMMUNITY SIZE

Community Size	<u>Population per Physician</u>		
	<u>General Practitioner</u>	<u>Specialist</u>	<u>Other</u>
150,000 and over	1,882	1,940	1,847
30,000-150,000	1,796	1,898	1,744
10,000-30,000	1,364	2,920	5,180
Under 10,000	2,375	25,590	17,850
Canadian Total	2,055	4,103	3,857
	<u>TOTAL</u>		
	630		
	604		
	788		
	1,881		
	977		

Information from the Provincial Medical Boards of the other three Atlantic Provinces to augment the data now being collected by the Medical Society of Nova Scotia. This will provide a more accurate estimate of the physicians working in the area.

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TABLE 2
RATIO OF POPULATION PER GENERAL PRACTITIONER
AND SPECIALIST IN CANADA BY COMMUNITY SIZE

Community Size	Population per Physician		
	Practitioner	Specialist	Other
150,000 and over	1,882	1,940	1,847
10,000-150,000	2,324	2,920	2,130
Under 10,000	2,375	27,290	17,890
Canadian Total	2,052	4,102	3,827

TABLE

600



1 It will be noted that the average population
2 per general practitioner is very similar in cities over
3 150,000 and from 30,000 to 150,000. It may or may not be
4 a reasonable assumption that these cities have a fairly
5 adequate supply of general practitioners to meet the de-
6 mands, but it would seem reasonable to assume that at least
7 as good a ratio should be required in smaller communities
8 and perhaps one to 1500 rural areas where a doctor cannot
9 care for as large a population.

10 6. The following table shows the number of phy-
11 sicians required in the Maritime Provinces and in the four
12 Atlantic Provinces, if a ratio of one general practitioner
13 per 1800, or one per 1500 is applied. It is emphasized
14 that these figures are for general practitioners only and
15 do not include specialists, but an estimate is made of the
16 total physician population based on the proportion of gen-
17 eral practitioners. In 1949 this constituted 49.2 percent
18 of the total physicians. As later figures become available
19 these estimates may be adjusted.

20 TABLE 3

21 ESTIMATE OF PHYSICIAN REQUIREMENTS BASED ON ONE
22 GENERAL PRACTITIONER PER 1800 OR 1 PER 1500 IN THE
23 THREE MARITIME PROVINCES AND IN THE
24 FOUR ATLANTIC PROVINCES

25 1960 Population	Four Atlantic	Three Mari-
	Provinces	time Provinces
26 Estimated requirement for	1,854,000	1,398,000
27 G.P.'s at 1 per 1800	1,030	777
28 Estimated requirement for		
29 G.P.'s at 1 per 1500	1,236	932

per general practitioner is very similar in other over 150,000 and from 30,000 to 150,000. It may or may not be a reasonable assumption that these cities have a fairly adequate supply of general practitioners to meet the demands, but it would seem reasonable to assume that at least as good a ratio should be required in smaller communities and perhaps one to 1500 rural areas where a doctor cannot care for as large a population.

The following table shows the number of physicians required in the Maritime Provinces and in the Atlantic Provinces, if a ratio of one general practitioner per 1800, or one per 1500 is applied. It is emphasized that these figures are for general practitioners only and do not include specialists, but an estimate is made of the total physician population based on the proportion of general practitioners. In 1949 this constituted 49.3 percent of the total physicians. As later figures become available these estimates may be adjusted.

TABLE 1

GENERAL PRACTITIONER PER 1800 OR 1 PER 1500 IN THE

MARITIME PROVINCES AND IN THE

1950 Population		Estimated requirement for	
Maritime Provinces	Atlantic Provinces	1,800,000	1,500,000
1,200,000	1,200,000	1,200,000	1,200,000
667	667	667	667
1,200,000	1,200,000	1,200,000	1,200,000
667	667	667	667



TABLE 3, Cont'd.

	Four Atlantic Provinces	Three Maritime Provinces
Estimated total requirement for all physicians if G.P.'s at 1 per 1800	2,093	1,579
Estimated total requirement for all physicians if G.P.'s at 1 per 1500	2,512	1,894
Present supply (1960)	1,528	1,251
Shortage based on 1-1800	565	258
Shortage based on 1-1500	984	643

This table shows that if general practitioners were available in this area at a ratio of 1 per 1800 persons we would require 565 doctors more than we now have in the four Atlantic Provinces, of whom 258 should be in the three Maritime Provinces. The major shortage of more than three hundred is in Newfoundland. The estimate for the Atlantic Provinces based on 1 per 1800 is not greatly different from the earliest estimate based on reaching the Canadian average of population per physician, both being approximately 600. If the ratio of 1 general practitioner per 1500 were applied to the population, it would appear that there was a shortage of 984 doctors in the four Atlantic Provinces, or 643 in the three Maritime Provinces.

7. The Canadian Sickness Survey in 1951 shows interesting comparisons of the volume of physician services in various regions of Canada based upon the number of home and office calls. This showed the Maritime Provinces to be approximately 14 percent below the Canadian average and

Maritime

Atlantic

Estimated total requirement

for all physicians in A.P.s

for all physicians in G.P.s

1,251	1,738
258	267
643	284

This table shows that if general practitioners were available in this area at a ratio of 1 per 1,500 persons we would require 267 doctors more than we now have in the four Atlantic Provinces, or whom 284 should be in the three Maritime Provinces. The major shortage of some three hundred is in Newfoundland. The estimate for the Atlantic Provinces based on 1 per 1,500 is not greatly different from the earliest estimate based on reaching the Canadian average of population per physician, both being approximately 600. If the ratio of 1 general practitioner per 1,500 were applied to the population, it would appear that there was a shortage of 267 doctors in the four Atlantic Provinces, or 284 in the three Maritime Provinces.

The Canadian Census Survey in 1951 shows

interesting comparisons of the volume of population services in various regions of Canada based upon the number of home and office calls. This shows the Maritime Provinces to be approximately 14 percent below the Canadian average and



31 percent below the highest figure in the Province of British Columbia, as shown in the following table.

TABLE 4

NUMBER OF DOCTOR'S CALLS (HOME AND OFFICE,
EXCLUDING CLINIC) PER 1000 POPULATION BY REGION

British Columbia	2,052
Ontario	1,999
Quebec	1,524
Maritimes	1,418
Prairies	1,298
Newfoundland	687
Canada	1,646

8. The following comparison of the volume of physician services in medically insured populations seems to show an even more striking deficit in the number of doctors so far as the Maritimes are concerned.

TABLE 5

Insured Families, Canadian Sickness Survey	2154 Physicians' services per 1,000
Insured Families, Swift Current	2340 Physicians' services per 1,000
Voluntary Medical Insurance Plans	2150 Physicians' services per 1,000
Maritime Medical Care	3254 Physicians' services per 1,000

If the clinic visits are included in the number of physician services shown in the preceeding table, the Maritimes have a ratio of approximately 1550 doctors' calls per 1,000 as compared with the insured groups shown above which for the most part range from 2150 to 2350 ex-

show the highest figure in the Province of

Ontario

Quebec

Maritimes

1,646

8. The following comparison of the volume of

physician services in medically insured populations seems

to show an even more striking deficit in the number of

doctors so far as the Maritimes are concerned.

Insured Families, Canadian
Sickness Survey

Insured Families,
1930 Survey

Voluntary Medical Insurance
Plans
per 1,000

in the clinics visited are included in the

number of physician services shown in the preceding table.

the Maritimes have a ratio of approximately 1,000 doctors

calls per 1,000 as compared with the insured groups shown

the most part range from 750 to 850 ex-



1 cept for the Maritime Medical Care group. Further study
2 is required, but it seems reasonable to base estimates of
3 the future demands for medical services on the demand al-
4 ready experienced in insured populations. These figures
5 suggest that in the Maritime Provinces there might be an
6 increase of at least 50 percent in the demand for medical
7 services if comprehensive medical services insurance were
8 introduced, i.e. from 1550 to 2200 or 2300. Such an in-
9 crease of 50% over the present number of 1251 physicians in
10 the three Maritime Provinces would bring the figure to
11 1876 doctors. As shown in Table 3, the estimate based on
12 one general practitioner per 1500 persons, and approxmiately
13 an equal number of specialists, was almost the same, 1894.
14 A fifty percent increase under insurance coverage does not
15 therefore seem an unrealistic estimate.

1876 doctors. As shown in Table 2, the estimate based on one general practitioner per 1500 persons, and approximately an equal number of specialists, was almost the same, 1904. A fifty percent increase under insurance coverage does not therefore seem an unrealistic estimate.

increase of at least 50 percent in the demand for medical services if comprehensive medical services insurance were introduced, i.e. from 1550 to 2200 or 2300. Such an increase of 50% over the present number of 1551 physicians in the three Maritime Provinces would bring the figure to suggest that in the Maritime Provinces there might be an



1 DR. KERR: Mr. Chairman and distinguished
2 members of the Commission, my task is a very simple one
3 today: I simply want to thank you for the courtesy you
4 have extended to us in allowing us to present our brief
5 to you which I now will formally present in the name of the
6 University.

7 It came to us with satisfaction that this
8 Commission has been appointed. We know the names of the
9 men and women who compose it and we feel it augurs well
10 for the future of the health services in this country that
11 you have been authorized to take this whole question under
12 your advisement, and we come to you with great pleasure,
13 and we are grateful to you for having allowed us to come
14 and present what is a very substantial brief.

15 Dalhousie is well-known to some members of
16 your Commission. We flatter ourselves with the thought
17 it is known to everyone, but we know there are members of
18 this Commission who know the University very intimately
19 and its interest in health services.

20 Perhaps I may say just this: that we have the
21 only medical school, the only dental school, the only
22 College of Pharmacy, the only School of Graduate Nursing
23 in the four Atlantic Provinces, so we feel that we occupy
24 a central and most strategic place in the whole question
25 of health services. We are the institution to which the
26 four Provinces look for their personnel in the health
27 field.

28 With your permission, Mr. Chairman, I shall
29 ask Dean Stewart of Medicine, Dean McLean of Dentistry
30 and Dean Hicks, the Vice-President of the University, who

members of the Commission. My task is a very simple one today: I simply want to thank you for the courtesy you have extended to us in allowing us to present our brief to you which I now will formally present in the name of the

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With your permission, Mr. Chairman, I shall

Dean Stewart of Medicine, Dean Holman of Dentistry and Dean Hicks, the Vice-President of the University, who



1 has come here this afternoon to represent the newly formed
2 Faculty of Health Professions, to proceed, and if you will
3 hear them they will present the subject matter under each
4 of their briefs.

5 May I conclude by thanking you very much,
6 sir, indeed, for letting us come.

7 THE CHAIRMAN: Thank you very much. Dean
8 Stewart?

9 DR. STEWART: Mr. Chairman and members of
10 the Commission, if I may, sir, I shall read the summary
11 dealing with the Faculty of Medicine, paragraph by para-
12 graph, and perhaps in a few instances comment briefly.

13 Faculty of Medicine

14 The Faculty of Medicine is concerned not
15 only with undergraduate medical education, but is the
16 major medical research centre of the region. Medical
17 scientists are educated in the pre-clinical departments in
18 anatomy, microanatomy, bacteriology, biochemistry, physio-
19 logic and pharmacology. Clinical specialists receive post-
20 graduate training in the affiliated hospitals and Pathology
21 Institute in medicine, surgery, obstetrics and gynaecology,
22 paediatrics, psychiatry, pathology, diagnostic and thera-
23 peutic radiology, anaesthesia, urology and neurosurgery.

24 There are a few medical and surgical special-
25 ties, but only a few, in which we do not in the affiliated
26 hospitals give teaching, and the only comment there is
27 that while this is officially under the hospitals them-
28 selves, they are approved by the Royal College of Physi-
29 cians and Surgeons. All of the staff in the clinical
30 departments are jointly appointed by the University and

say them they will present the subject matter under each

of their subject.

May I conclude by thanking you very much.

Mr. Chairman, for letting us come.

THE CHAIRMAN: Thank you very much. Good

Stewart?

DR. STEWART: Mr. Chairman and members of

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Faculty of Medicine

The Faculty of Medicine is concerned not

only with undergraduate medical education, but is also

major medical research centre of the region. Medical

anatomy, microanatomy, histology, biochemistry, and

logy and pharmacology. Clinical medicine, the medical part

graduate training in the affiliated hospitals and clinics

Institute in medicine, surgery, obstetrics and gynaecology,

paediatrics, psychiatry, pathology, dermatology and venere-

gic radiology, anaesthetics, radiology and neurology.

There are a few medical and surgical hospitals

ties, but only a few, in which we do not in the affiliated

hospitals give teaching, and the only comment there is

that while this is official, under the hospitals them-

selves, they are approved as the Royal College of Surge-

ons and Surgeons. All of the staff in the clinical

departments are jointly appointed by the University and



1 the hospitals, so in effect it is the teachers of the
2 University clinical departments who are responsible for
3 this, though in their capacity as head of a hospital
4 department and not as a professor in our University.

5 The Faculty operates the most extensive
6 program in Canada for the continuing medical education of
7 general practitioners throughout the Atlantic Provinces.

8 (M-69)*

9 This, I think, may be worthy of brief
10 comment, sir. It was started a few years ago by the
11 University on a grant from the Kellogg Foundation. There
12 is some question in the minds of some people as to how
13 far a University should go in keeping its graduates edu-
14 cated after they have received their degrees, but with the
15 rapidly growing knowledge in medicine it becomes increa-
16 singly essential that doctors -- and this is true of others
17 as well -- must be kept up-to-date, and the program of our
18 post-graduate division which is in part centralized in
19 courses in Halifax, but in part carried out in many
20 centres throughout the Atlantic Provinces, is by far the
21 largest such program for continuing education carried out
22 anywhere in Canada, and it places a very heavy burden on
23 the staff of our clinical departments.

24 The Faculty provides all courses in the
25 medical sciences for dental students, and assists in the
26 scientific and clinical training of other health personnel,
27 including nurses, pharmacists, dental hygienists and
28 medical technicians. (M-58, M-72)

29 We elaborate a little on that in various

30 * All cross references are by paragraph number.

the hospitals, so in effect it is the teachers of the

university clinical departments who are responsible for

this, though in their capacity as head of a hospital

department and not as a professor in our University.

The Faculty Committee has been working

program in Canada for the continuing medical education of

general practitioners throughout the Atlantic Provinces.

This, I think, may be worthy of praise

comment, sir. It was started a few years ago by the

university as a part of its continuing medical education

is a part of the continuing medical education program

for a University should go in keeping its graduates edu-

cated after they have passed their medical examinations

rapidly growing knowledge in medicine it becomes neces-

sarily essential that doctors -- and this is true of others

as well -- must be kept up-to-date, and the program of con-

tinuing medical education which is in part centralized in

courses in Halifax, but in part carried out in many

centres throughout the Atlantic Provinces, is by far the

largest and most comprehensive continuing medical education

program in the Atlantic Provinces.

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including nurses, pharmacists, dental hygienists and

other health personnel.

We elaborate a little on that in various

* All cross references are by paragraph number.



1 parts of the brief. Certainly a great deal more teaching
2 is done than through medical students within the Faculty
3 of Medicine.

4 More than 85 percent of English-speaking
5 medical students from the four Atlantic Provinces study
6 at Dalhousie. (Appendix D)

7 We have an appendix giving further informa-
8 tion on that. It ranges from about 79 to 87% of the total
9 of all students to enter medicine over the past ten years.
10 It was as low as 79 one year, and as high as 87, but since
11 there is a large part of New Brunswick which is French,
12 most of them go to Laval and the University of Montreal,
13 and we have a varying percentage of from 81 to 85,
14 averaging 82% that come to Dalhousie.

15 Approximately 70 percent of the doctors
16 entering practice in the four provinces are Dalhousie
17 graduates. (Appendix E)

18 We do not have exactly accurate information,
19 but we are collecting it, and we could provide it at a
20 later date. We have tabulations up to 1950, but we would
21 like to get the information for the last ten-year period
22 from 1951 to 1960. However, it is probably of that order
23 and may be a little higher.

24 The number of students from the Atlantic
25 Provinces seeking admission to Medicine has increased
26 during the past two years. There is no decline in the
27 academic calibre of our medical students. (M-22, M-29-30)

28 These two points are worth a brief comment.
29 First, that in common with every other medical school in
30 North America that I know of there was a falling off from

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from 1921 to 1926. However, it is probably of that order
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More than 85 percent of English-speaking

of Medicine.



1 1954 after the peak of the veteran intake had passed, and
2 for two or three years the group of younger people who did
3 not have any military experience, but who graduated, some
4 of them with a Master's or Ph.D. had waited to get into
5 medicine. After that passed there was a lull, a considerable
6 falling off, and the upsurge in general university
7 enrolment which began about five or six years ago because
8 of the increased birthrate in the late 30's, began three
9 or four years later to enter the medical school -- at
10 least, in this medical school -- so that in September 1960
11 we had a 40% increase in the number of students from the
12 four Atlantic Provinces seeking admission, and in 1961 we
13 have had a further increase of 30% over the preceding year.
14 By next Fall we will probably have a full class from the
15 four Atlantic Provinces not leaving any place for foreign
16 students, and in the following year unless we can increase
17 our facilities we will be turning down qualified candidates.
18 That is a guess, but it would appear to be reasonable.

19 The full-time staff of the pre-clinical
20 sciences has increased in recent years from sixteen to
21 thirty-one and of the clinical departments from two to
22 twelve. The part-time staff has increased to 127. (M-9)

23 There has been, as we indicate in a later
24 section, a very large increase particularly since 1954 in
25 the expenditures of the medical school, much of it --
26 almost all of it -- devoted to increase of staff.

27 Several improvements have been made in the
28 programs of medical education at Dalhousie and tremendous
29 growth has occurred in medical research in recent years.

30 (M-50-51)

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any military experience, but who graduated, some

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Several improvements have been made in the

programs of medical education at Dalhousie and throughout

growth has occurred in medical research in recent years.



1 This is also documented throughout the
2 report, and perhaps the most striking figure is that on
3 research projects in the various fields of medical
4 research for which grants are made by the National
5 Research Council, or now the Medical Research Council,
6 the Department of National Health, Defence Research Board,
7 and other national agencies, in 1946 we had one little
8 grant of \$3,400 in this medical school; in 1954 -- and I
9 choose that year because it happens to be the first year
10 I was Dean -- the figure reached \$80,000 and this year it
11 is more than \$320,000. These are outside the funds that
12 are mentioned in our brief as medical school funds. These
13 are funds for medical research that come in in individual
14 grants.

15 The University has been able to finance
16 these improvements in medical education and the increase
17 in staff by obtaining larger grants from the Governments
18 of the four Atlantic Provinces and from various other
19 sources. (F-15-17)

20 This is expanded upon in the sections of the
21 brief which are mentioned, F-15 and 17, which indicate the
22 fact we will be making representations to the Royal
23 Commission on Higher Education in New Brunswick in the
24 hope that Province will be able to support a program in
25 the Faculties of Medicine and Dentistry more than it has
26 done in the past, and we emphasize the great help we have
27 obtained from the Governments of Nova Scotia and Newfound-
28 land in recent years for these two faculties.

29 Because of the increase in students seeking
30 admission to Medicine and the shortage of doctors in this



REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

1. The following is a summary of the work done by the Commission during the year 1954-55.

2. Research projects in the various fields of medical

3. research for which grants are made by the National

4. Institutes of Health, and the various other

5. agencies, have been carried out during the year.

6. and other national agencies, in 1954 we had one little

7. grant of \$3,400 in this medical school; in 1954 -- and I

8. am sure that your Commission is aware of the fact that

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10. is more than \$20,000. These are outside the funds that

11. are mentioned in our brief as medical school funds. These

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15. these improvements in medical education and the increase

16. in staff by obtaining larger grants from the Government

17. of the four Atlantic Provinces and from various other

18. sources. (P-15-17)

19. This is expanded upon in the sections of the

20. brief which are mentioned, P-15 and 17, which indicate

21. fact we will be making representations to the Royal

22. Commission on the subject of the medical school.

23. hope that Province will be able to support a program in

24. the Faculties of Medicine and Dentistry more than it has

25. done in the past, and we emphasize the great help we have

26. obtained from the Government of Nova Scotia and Newfoundland

27. and in recent years for these two faculties.

28. Because of the increase in students seeking

29. admission to Medicine and the shortage of doctors in this



1 region, there is a need to expand the Medical School to
2 admit at least 75 and eventually 100 medical students per
3 year. This shortage will become much more acute as
4 medical insurance plans expand, whether voluntary or
5 Government-financed. Facilities should be provided also
6 for at least 25 and, if necessary, 50 dental students in
7 the medical science departments. (M-25-27)

8 The facilities, as Dean McLean will mention,
9 of the dental school are now available in clinical depart-
10 ments for such students.

11 Present facilities are grossly inadequate,
12 except in the Departments of Pathology and Bacteriology.
13 That section was provided by the Provincial Government of
14 Nova Scotia within the past year in addition to the patho-
15 logy institute. In order to permit the expansion in enrol-
16 ment and to provide much-needed research facilities, a new
17 Medical Sciences Building is required, which will cost
18 approximately \$4,500,000. Clinical research facilities
19 must also be expanded by remodelling the Dalhousie Public
20 Health Clinic at a cost of approximately \$250,000. (M-10,
21 Appendix B)

22 Most of the affiliated teaching hospitals
23 have recently enlarged or are planning to expand their
24 facilities. The Minister of Health this morning mentioned
25 the increase in the Victoria General, but all of the other
26 hospitals in the City have expanded too. By 1965 teaching
27 units in these hospitals will be adequate for 75 students
28 in the senior year. (M-10(e))

29 There should be at least 10 teaching beds
30 and closed teaching units for each student in the senior



region, there is a need to expand the Medical School to
at least 100 beds in the hospital for medical students
and to provide for the necessary clinical facilities
for at least 25 and, if necessary, 50 dental students in
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approximately \$100,000. It must also be expanded by remodeling the Dalhousie Building
which is a part of the existing hospital.

Appendix B)

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the increase in the Victoria General, but all of the other
hospitals in the province are also planning to expand
units in these hospitals will be adequate for 75 students
in the senior year. (M-10(e))

There should be at least 10 teaching beds



1 year, so we would need 750 beds and we expect to have
2 those. I think it should be said we have excellent clinical
3 facilities here, and though this is a relatively small
4 city the fact we have a referral centre for the whole
5 Province makes it possible to operate a medical school and
6 post-graduate programs of much greater magnitude than
7 would be possible in a small city otherwise. This is a
8 historic accident, that we have one of the few hospitals
9 operated by a Provincial Government. In other places,
10 cities of this size would have a municipal hospital and
11 there would be infiltrations of patients: 40% of the
12 patients come from other parts of the Province, and that
13 means we have a very wide variety of clinical material of
14 the more difficult type.

15 Unless there is a very large increase in the
16 number of students seeking admission to medicine from the
17 four Atlantic Provinces, the proposed enlargement of the
18 Medical School will be adequate for the immediate future,
19 but eventually another medical school may be required in
20 the region. (M-28)

21 Our suggestion that there be an enlargement
22 of Dalhousie for the time being to meet the needs is not
23 from any selfish motive but simply from the fact there are
24 not enough students from any one of the other Provinces to
25 warrant the establishment of another medical school.
26 There is no medical school in Canada or the United States
27 for less than 40 students; there are only three in the
28 forties. No Province in the four Atlantic Provinces is
29 providing any more than about 16 to 20 students per year
30 in any one Province -- not quite enough to establish a

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1 medical school unless we have a very large increase in
2 recruitment, and at that time Dalhousie would be quite
3 happy to see another school established.

4 Medical education is very expensive. The
5 average cost per medical student in 1961-1962 will be
6 \$3,250. Provincial grants provide \$1,080 (33.2%), federal
7 grants \$172 (5.3%), which we think is very inadequate to
8 say the least, tuition fees \$564 (17.4%) - although the
9 students consider their costs are high, it is only a tiny
10 proportion of what the University has to provide, because
11 they provide \$1,434 per student or 44.1%. In order to
12 provide the increases we can see within the foreseeable
13 future with the absolute minimum needs to maintain our
14 University as a good teaching institution, we need some-
15 thing in the order of \$300,000, and if we increase our
16 enrolment it would be even more than that.

17 Such an expensive educational program could
18 not be operated at an adequate level by a privately endowed
19 institution without considerable assistance from Govern-
20 ments. It is very doubtful whether the private sources
21 of the University can contribute to future increases at
22 the same rate as in the past seven years. Since 1954
23 total Provincial grants provided a total of \$688,677,
24 University sources provided \$721,666, that is of the
25 increase, and medical research grants amounted to \$675,731.
26 The Medical Alumni Fund provided \$140,000 for the capital
27 improvements in the Medical School buildings since 1954,
28 and the Government of Nova Scotia constructed the addition
29 to the Pathology Institute. (F-11-18) - and of which I
30 do not have an estimate of the cost.



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to the Pathology Institute. (7-11-56) - and of which I
do not have an estimate of the cost.



1 The system of provincial grants is not set
2 up on a stable basis and an annual appeal has to be made
3 to all four Governments. (M-6, F-3-8)

4 This is at least a little awkward as far as
5 we are concerned, and we are appealing to the Royal Commis-
6 sion on Higher Education in New Brunswick for co-operation
7 with the other Provinces in getting a standard system of
8 allocating these costs and sharing them.

9 It is respectfully recommended to the Royal
10 Commission on Health Services:

11 (a) That the Government of Canada provide
12 scholarships and bursaries for medical
13 students at a rate of \$2,000 per year, and
14 that service requirements, if any, following
15 graduation should not interfere with the
16 post-graduate training of specialists.

17 (M-31-32, M-71) Mention was made of the
18 Newfoundland plan today earlier, and we
19 think this is good, but it does require the
20 return of the student immediately after
21 graduation to that Province for four years.
22 We would hope a national plan might be
23 developed in which service anywhere within
24 the country would qualify if there is to be
25 any such service regulation for those who
26 receive any help. We think the great shor-
27 tage of the students entering and the length
28 of time to meet the shortage of doctors in
29 this area both require such a system of
30 support for students.

The system of provincial grants is not set

up on a stable basis and an annual appeal has to be made

to all four Governments. (M-2, P-3-6)

This is at least a little awkward as far as

we are concerned, and we are appealing to the Royal Commission

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think this is good, but it does require the

return of the student immediately after

graduation to plan training for four years.

We would hope a national plan might be

developed in which service agencies within

the country would qualify if there is to be

any such service requirement for those who

face all the student anxiety and the length

of time to meet the shortage of doctors in

this area with a system of



1 (b) That the Government of Canada provide
2 substantial capital grants to aid in the
3 expansion of both teaching and research
4 facilities in existing medical schools. The
5 immediate needs of Dalhousie are estimated
6 at \$4,750,000. (M-54-57) We hope you will
7 look with favour on the Farquharson Committee
8 which recommended that Federal Government
9 funds for building of medical research
10 buildings be provided at medical schools and
11 affiliated teaching hospitals.

12 (c) That annual grants be made to medical
13 schools to permit an increase in teaching
14 staff in pre-clinical and clinical depart-
15 ments and to pay higher salaries to full-time
16 staff and adequate honoraria to part-time
17 clinical teachers. These grants should be
18 at least \$1,000 per student now and increased
19 to \$2,000 over a five-year period. (M-36,
20 M-45-49, M-71, M-77)

21 Those are the three main financial ones:
22 one, concerning help to students; secondly, for buildings
23 and thirdly, for operating expenses.

(d) That the Government of Canada provide substantial capital grants to aid in the expansion of both teaching and research facilities in existing medical schools. The immediate needs of laboratories are estimated at \$4,750,000. (M-54-97) We hope you will look with favour on the St. Lawrence Committee

funds for building of medical research buildings be provided at medical schools and affiliated teaching hospitals.

(e) That annual grants be made to medical schools to permit an increase in teaching staff in pre-clinical and clinical departments and to pay higher salaries to full time staff and adequate honoraria to part-time clinical teachers. These grants should be at least \$1,000 per student per year and increased to \$2,000 over a five year period. (M-56)

These are the three main financial areas one, concerning help to students, secondly, for buildings and thirdly, for operating expenses.



(d) That in any system of medical services insurance there be specific safeguards to ensure development and maintenance of teaching units of adequate size (a) in the hospitals affiliated with medical schools for undergraduate teaching, and (b) in hospitals approved by the Royal College of Physicians and Surgeons for post-graduate training in specialties. (M-15-16) Some of those are not in medical school centres. There is still a certain amount of medical training which will only be given under the old type of apprenticeship system and which cannot be given simply by demonstrations, and if every patient has his own doctor in the teaching wards the system of medical education cannot go on; there have to be closed teaching wards under the care of a team, the team of specialist in training, the intern and the graduate in his fourth year in a clinical partnership.

(e) That any recommendation of the Commission relating to medical education permit free choice of the University as to whether or not it retains supervision over the year of internship. (M-14) That is one of the peculiarities of Dalhousie which we share with two of the French Universities in Quebec. We don't grant the degree until the internship has been completed as well as four years



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teaching units of adequate size (a) in the
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recommendations of the Commission which we share
with one of the French Universities in Quebec.
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ship has been completed as well as four years



1 of training. There are Government regula-
2 tions which date from the time of graduation
3 rather than from the time of licensure which
4 make it difficult for our students.

5 (f) That plans for extension of health
6 services be preceded by a realistic estimate
7 of the personnel requirements, especially
8 the physician requirements, and that suitable
9 provision be made to ensure the necessary
10 increase in physicians before any extensive
11 increase in health services is begun. This
12 will require an interval of at least ten
13 years. (M-39-42) In my opinion, sir, and
14 in the opinion expressed in the brief, that
15 is an underestimate rather than an overesti-
16 mate. We have suggested in some of the
17 figures given that there may be a 50%
18 increase in some of the three Atlantic
19 Provinces, and it may be even greater in
20 Newfoundland because the shortage is
21 greater there. If we had a system of
22 scholarships it would be at least three
23 years before the student would complete his
24 pre-medical training, and it would be at
25 least that time before we could get a school.
26 By the time those students enter it would be
27 then four or five years would have passed,
28 it would be then four or five years before
29 they could practise, and it would be ten
30 years after that before we could even come

of training. There are Government regula-
 tions which date from the time of graduation
 which are now obsolete. It is necessary to
 make it difficult for our students.
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 of the personnel requirements, especially
 the physician requirements, and that suitable
 provision be made to ensure the necessary
 increase in physicians before any extensive
 increase in health services is begun. This
 will require an interval of at least ten
 years. (M-39-42) In my opinion, sir, and
 in the opinion expressed in the letter, that
 is an understatement rather than an overesti-
 mate. We have suggested in some of the
 figures given that there may be a 50%
 increase in some of the three Atlantic
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 by the time those students enter it would be
 it would be three or four or five years before
 they could practice, and it would be ten
 years after that before we could even com-



1 about two-thirds of the way towards meeting
2 the Canadian average of the ratio of doctors
3 to population in these four Provinces, and
4 it would still be a way below the require-
5 ment if an insurance plan came into being.

6 (g) That Universities be asked to explore
7 methods of shortening the duration of
8 medical education by lengthening the aca-
9 demic term. (M-33-35) This is one way in
10 which possibly the length of course might
11 be reduced. We cannot reduce the length
12 of course in actual teaching time, but if
13 students didn't have to obtain a fair part
14 of their cost of education by summer work
15 we might be able to shorten it.

16 (h) That methods be explored for improving
17 the clinical training of immigrant doctors
18 before licensure in Canada. (M-43-44) We
19 don't think that the problem of the shortage
20 of doctors can be met solely by having more
21 immigrant doctors come into the country.

22 Thank you very much, sir. That completes
23 that section, and I will hand over to Dr. McLean.

24 DR. McLEAN: Mr. Chairman, members of the
25 Commission, the Faculty of Dentistry serves as the only
26 center for dental education (para. D46), and the chief
27 source of dental practitioners for the Atlantic region.

28 The present staff (para. D29 and D34) and
29 physical facilities (para. D38) are excellent, although
30 severely limited in number and size, even for the maximum

the Canadian average of the ratio of doctors to population in these four Provinces, and it would still be a way below the requirement if an increase in the number of dentists is an inevitable result of the expansion of the University as stated to explore

methods of shortening the duration of medical education by intensifying the academic training. (M-34-35) This is one way in

which the present situation might be relieved. We cannot reduce the length of course in actual teaching time, but if students should have to obtain a fair part of their cost of education by summer work we might be able to shorten it.

(n) That method be explored for improving the clinical training of dentists before licensure in Canada. (M-43-44) We don't think that the problem of the shortage of doctors can be met solely by having more dentists come into the country. There are very few, sir, that complete

that section, and I will have over Dr. McLean, Dr. McLean, Mr. Chairman, members of the Commission, the Faculty of Dentistry serves as the only center for dental education (para. 146), and the chief source of dental practitioners for the Atlantic region. The present staff (para. 148) are excellent, although

very limited in number and are, as the Commission



1 number of students now possible in the school.

2 The Faculty has made dramatic improvements
3 in staff, physical facilities, and teaching programs
4 within the past eight years (paras. D13, D24, D29, D38,
5 D39, D74, D78, G7). Much improvement was made possible,
6 initially, by generous financial support for annual opera-
7 tion from the W.K. Kellogg Foundation, and more recently
8 by the greatly appreciated increase in the grants from
9 provincial governments (Section F).

10 There is need, however, for much more
11 generous financial assistance for the operation of the
12 present Dental Faculty, and on a more stable basis.
13 Present deficits must be eliminated (para. D74). More,
14 qualified teachers - particularly on a full-time basis,
15 are required now (para. D31), as well as for any future
16 increase in the size of the school, as are technical staff
17 who would contribute to an increase in the efficiency
18 and effectiveness of the teaching program (para. D36).
19 Salaries of teachers should be improved immediately
20 (Paras. D32, D33, D34).

21 There should be an immediate improvement in
22 the facilities for the teaching of dental students in
23 hospitals.

24 To stimulate the development of dental
25 research staff (paras. D23, D28) and teachers, it is
26 recommended that money be provided to subsidize persons
27 engaged in advanced education programs for these purposes.

28 An extension of short post-graduate and
29 refresher courses should be developed now, but graduate
30 and specialty education in dentistry is not possible at

2. D39, D7, D8, 07. Much improvement was made possible.

Initially, by generous financial support for annual operation from the W.A. Kellogg Foundation, and more recently by the greatly appreciated increase in the grants from provincial governments (Section 7).

There is need, however, for much more

generous financial assistance for the operation of the

present Dental Faculty, and on a more stable basis.

Present deficits must be eliminated (para. D41). More

qualified teachers - particularly on a full-time basis,

are required now (para. D81), as well as for any future

increase in the size of the school, as the technical staff

who would contribute to an increase in the attendance

and effectiveness of the teaching, program (para. D86).

Salaries of teachers should be improved immediately

There should be an immediate improvement in

the facilities for the teaching of dental students in

hospitals.

To stimulate the development of dental

research staff (para. D39, D83) and teachers, it is

recommended that money be provided to encourage persons

engaged in advanced education programs for these purposes.

An extension of short post-graduate and

refresher courses should be developed now, but emphasis

and specialty education in dentistry is not possible at



1 Dalhousie until there has been an appreciable increase in
2 the size of the Faculty (para. D24).

3 At such time as the class size is suffi-
4 ciently large (and we suggest forty to sixty students),
5 basic medical science departments, with adequate research
6 facilities, should be established as an integral part of
7 the Dental Faculty (para. D9). We feel that this will
8 not only overcome some of the difficulties which may
9 arise between medicine and dentistry, but it is our convic-
10 tion that dental research and dental programs will advance
11 more rapidly when science and teachers in the basic science
12 departments are within the Faculty of Dalhousie and their
13 efforts orientated to dentistry. We are not criticizing
14 the present arrangements.

15 There is an urgent need to increase the
16 number of dental practitioners in the Atlantic region
17 (paras. D58-D71, incl.).

18 The Faculty of Dentistry at Dalhousie Univer-
19 sity now admits all qualified students from the Atlantic
20 region who seek admission, and it could accommodate double
21 the number.

22 Further to the comment this morning, I
23 might add our enrolment is up a little bit this year, and
24 the indications at this stage are that it will continue
25 to increase. If, however, as has been pointed out, the
26 recruitment to the dental schools is influenced to a very
27 marked degree by the number of practising dentists, then
28 the very shortage of dentists would militate against the
29 kind of enrolment we would like to see. We have discovered
30 recently since this report was prepared that 75% of our

Dalhousie until there has been an appreciable increase in the size of the Faculty (para. D94).

At such time as the class size is sufficiently large (and we suggest forty to sixty students), basic medical science departments, with adequate research facilities, should be established as an integral part of the Dental Faculty (para. D9). We feel that this will not only overcome some of the difficulties which may

arise in connection with the establishment of a dental program with advance departments are within the Faculty of Dalhousie and their efforts extended to dentistry. We are not criticizing the present arrangements.

There is an urgent need to increase the number of dental students in the Faculty of Dalhousie (para. D98-D101, incl.).

The Faculty of Dentistry at Dalhousie University now admits all qualified students from the Atlantic region who seek admission, and it could accommodate double the number.

Further to the current discussion, I might add our enrollment is up a factor of this year, and the indications at this stage are that it will increase. If, however, as has been pointed out, the recruitment to the dental schools is not held to a very marked degree by the number of practicing dentists, then the very shortage of dentists would militate against the kind of enrollment we would like to see. We have discovered recently since this report was prepared that 75% of our



1 students come from families whose incomes are between the
2 figures of \$4,000 and \$10,000 per annum. In other words,
3 there is probably a large body of potential dental students
4 in the high schools in and around the Province who, for
5 financial reasons, are unable to consider dentistry as a
6 profession.

7 Even if the school was operating at capacity
8 with the present facilities, it could not provide, within
9 the space of twenty years, additional dentists for the
10 Atlantic region, in sufficient numbers to reach even the
11 present Canadian average population per dentist (para. D70).

12 Strong incentives are necessary to assure
13 the required number and quality of students (para. D97).

14 It is therefore recommended that these incen-
15 tives include:

16 (1) Annual scholarships, each in the amount
17 of \$1,500 to \$2,000, for the four years in
18 the Faculty of Dentistry, to permit the
19 Dental Faculty to compete with other areas
20 of advanced education, for students with
21 high academic standing. Dean Stewart has
22 referred, I am sure, in his report to grants
23 which are available to graduates of the
24 Arts and Sciences Faculty who wish to go on
25 into the sciences.

26 (2) A number of substantial bursaries for
27 needy students which would assist them for
28 at least the four-year period in the Faculty
29 of Dentistry. To be effective, the amount
30 should be about \$1,000 a year, which, if

students come from families whose incomes are between the figures of \$4,000 and \$10,000 per annum. In other words, there is probably a large body of potential dental students in the high schools in and around the Province who, for financial reasons, are unable to consider dentistry as a profession.

Even if the school was operating at capacity with the present facilities, it could not provide, within

the Atlantic region, in sufficient numbers to reach even the present Canadian average population per dentist (year, 1970).

Strong incentives are necessary to assure the required number and quality of students (year, 1971).

These include:

- (1) Annual scholarships, each in the amount of \$1,500 to \$2,000, for the four years in the Faculty of Dentistry, to permit the Dental Faculty to compete with other means of advanced education, for students with high academic standing. Dean Stewart has referred, I am sure, in his report to grants which are available to graduates of the Arts and Sciences Faculty who wish to go on into the sciences.
- (2) A number of substantial bursaries for needy students which would assist them for at least the four-year period in the Faculty of Dentistry. To be effective, the amount should be about \$1,000 a year, which is



1 added to summer earnings, would cover the
2 \$1,500 or \$2,000 per year which students
3 estimate is their personal annual cost. I
4 might add just there that a more recent
5 investigation in the Faculty would indicate
6 that the figure was closer to \$2,000;
7 indeed, the range runs from \$1,200 to \$3,800
8 per year, depending on whether the student
9 is married, I presume, but the bulk of the
10 students find the cost around \$1,800 to
11 \$2,000 per year. Such bursaries should be
12 on a national basis, preferably with 'no
13 strings' other than an undertaking to serve
14 in Canada.

15 (3) Student subsidies similar to those
16 provided by the Royal Canadian Dental Corps,
17 sufficient to cover the cost of dental edu-
18 cation and living expenses, in return for
19 which the student would agree to some form
20 of public service for a specified number of
21 years.

22 The first two methods are to be preferred,
23 because they allow the graduate to have greater freedom
24 in the selection of a career, whether it be general or
25 specialized practice, research, teaching, or public health.
26 We have had experience of excellent students who would be
27 potentially good teachers - and there is a great shortage
28 of full-time dental teachers in Canada - who have been
29 committed to one of the subsidy programs and cannot get
30 out of them in order to take part in teaching. A

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of full-time dental teachers in Canada - who have been

committed to one of the subsidy programs and cannot get

out of them in order to take part in teaching. A



1 reference was made this morning to the Dental Corps plan,
2 and perhaps it would be pertinent for me to make a comment
3 at this time. I think that while it is true Dalhousie
4 University has provided proportionately more dental gradu-
5 ates than the other Canadian dental schools, on the other
6 hand, it must be recognized that the armed services are
7 as valuable to this Province as they are to any other part
8 of Canada, and the requirements of the Dental Corps should
9 also be met. It is too soon to say, I think, really,
10 with any degree of accuracy of what has happened to any
11 of these students who have completed their term of contract
12 in the Corps. The plan and the number of students have
13 not been sufficiently large to get a good idea of what is
14 going to happen. I think it is safe to say that a fair
15 proportion of them, having moved to other parts of the
16 country, may continue to live there. I recall seeing a
17 study not many years ago in the United States of what
18 happened to college students who went to study in institu-
19 tions outside of their home state, and, of course, as one
20 might expect, those who went to outside institutions and
21 stayed there were quite larger than those who trained in
22 their own home states.

23 Because of the shortage of dental personnel,
24 implementation of a full program of state-financed dental
25 care seems impractical at this time. Any state dental
26 health care plan should be preceded by a program which will
27 provide greatly increased numbers of dentists.

28 Further, any solution to the manpower problem
29 which results in a lowering of professional standards of
30 dental care, will compound the difficulties by discouraging

at this time. I think that while it is true that the dental profession in this country is not as well organized as it is in some of the other countries, on the other hand, it must be recognized that the armed services are as valuable to this Province as they are to any other part of Canada, and the dental profession in this country is also being met. It is too soon to say, I think, really, with any degree of accuracy of what has happened to any of the dental profession in the armed services. The plan and the number of students have not been sufficiently large to get a good idea of what is going to happen. I think it is safe to say that a fair proportion of them, having moved to other parts of the country, may continue to live there. I recall seeing a study not many years ago in the United States of what happened to college students who went to study in institutions outside of their home state, and, of course, as one might expect, those who went to outside institutions and stayed there were quite larger than those who trained in their own home states.

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Further, any solution to the manpower problem which results in a lowering of professional standards of dental care, will compound the difficulties by discouraging



1 recruitment to the professions, and a deterioration in the
2 dental schools.

3 It cannot be emphasized too strongly that
4 from the day a decision is reached to provide a new school,
5 a minimum of six years will elapse before the first student
6 graduates from it. This includes minimal time for planning
7 and construction, recruitment of staff and a minimum of
8 four years required to educate a dental student beyond his
9 pre-professional level.

10 In considering any extension of facilities
11 for dental education in the Atlantic Provinces, the
12 following points are pertinent (D105):

13 (1) The first step in a program for the
14 expansion of dental education facilities
15 in the Atlantic region should be an increase
16 in the size of the existing school.

17 (2) Greater economy could be achieve with
18 a class of sixty students, but this figure
19 should not be exceeded.

20 (3) The size and location of the dental
21 school is determined, in part, by the neces-
22 sity that it be an integral part of the
23 university, and by the size of the community
24 in which it is located. It is doubtful
25 whether an urban population appreciably less
26 than 100,000 would provide the number of
27 patients required for the variety of
28 teaching experience in the clinical program.

29 Part of the personnel problem can be solved
30 by the more extensive use of auxiliaries in practice.



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by the more extensive use of auxiliaries in practice.



1 These include the dental assistant, the dental hygienist,
2 and the dental technician. Training programs for these
3 groups should be developed.

4 Since graduates of the dental school may
5 choose to practice in any area of Canada, it is recommended
6 that the Federal Government provide assistance to univer-
7 sities:

8 (1) For the annual operation of dental
9 schools in the amount of \$2,000 per student;
10 and

11 (2) for the annual operation of schools
12 of dental hygiene in the amount of \$700 per
13 student; and

14 (3) for capital construction at the rate of
15 \$20,000 per student.

16 It is reasonable to expect that auxiliaries
17 can be trained to do more of the technical procedures
18 under the direct responsibility of the dental practitioner
19 than is now legally permissible. This possibility should
20 be explored on an experimental basis, to determine the
21 extent to which additional duties can be assigned in an
22 effective and economically sound manner.

23 It is recommended that a system of Federal-
24 Provincial Public Health Grants be implemented, specifi-
25 cally for dental health problems, similar to those avail-
26 able for medicine. These should provide funds for clini-
27 cal research and other studies such as the project
28 suggested in the preceding paragraph; for specialized
29 treatment centers such as cleft palate clinics, diagnostic
30 centers (particularly in orthodontics and other specialty



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treatment centers such as cleft palate clinics, diagnostic

centers (particularly in orthodontics and other specialty



1 areas); and for the extension of dental public health
2 services.

3 Thank you very much.

4 DR. HICKS: Mr. Chairman and Commissioners,
5 Dalhousie University established a Faculty of Health
6 Services only this year. At the present time this Faculty
7 comprises a School of Nursing which the University has
8 operated for about 12 years and a College of Pharmacy
9 which has been operated in Nova Scotia for many years but
10 which came to Dalhousie University only at the commencement
11 of this term. As yet a full-time Dean of this Faculty
12 has not been selected, which accounts for the reason why
13 I am making this submission.

14 To deal first with the School of Nursing:

15 The Dalhousie School of Nursing is at present providing a
16 course leading to the degree of Bachelor of Nursing as well
17 as a diploma course in :

- 18 (1) Nursing service administration;
19 (2) Public Health Nursing;
20 (3) Teaching in Schools of Nursing.

21 There would appear to be a need for eight
22 hundred additional nurses in Nova Scotia within the next
23 five or six years. The existing facilities for nursing
24 training can only meet a portion of this requirement. The
25 feasibility of establishing a central school of nursing in
26 Nova Scotia on an experimental basis ought to be investi-
27 gated. Financial support for nursing education at Dal-
28 housie ought to be reviewed and assurances given that
29 adequate support will be forthcoming on a permanent basis.

30 College of Pharmacy: The College of Pharmacy,



1 (1) and the extension of dental public health

2 (2) (3)

3 Thank you very much.

4 DR. HICKS: Mr. Chairman and Commissioners,

5 California University established a Faculty of Health

6 in 1911. At that time the Faculty of Health

7 consisted of a School of Dentistry and the University was

8 operated for about 12 years and a College of Pharmacy

9 which has been merged in the Faculty for many years has

10 been added to the Faculty of Health. At the present time

11 of this term. As yet a full-time Dean of this Faculty

12 has not been selected, which is a matter for the Faculty to

13 I am making this submission.

14 To deal first with the School of Nursing:

15 The California School of Nursing is at present a

16 four-year course in the degree of Bachelor of Science in

17 as a diploma course in:

18 (1) Public Health Nursing

19 (2) Public Health Nursing

20 (3) Teaching in Schools of Nursing.

21 There would appear to be a need for eight

22 additional places in the School of Nursing.

23 At the present time, the School of Nursing is

24 a part of the University of California, and the

25 Faculty of Health is a part of the University of

26 Nova Scotia on an experimental basis ought to be investi-

27 gated. Financial support for nursing education at Dal-

28 housie ought to be reviewed and assurances given that

29 adequate support will be forthcoming on a permanent basis.

30 College of Pharmacy: The College of Pharmacy



1 as a division of a Dalhousie Faculty, is only in its first
2 years of operation, and it is not yet easy to state with
3 certainty and in detail what the future requirements will
4 be.

5 Enrolment for the present year has increased
6 more than fifty percent over that of the previous year.
7 Most of this increase is accounted for by students under-
8 taking a four-year degree course which is being offered
9 for the first time in the Atlantic Provinces.

10 Cost of operation for the current year is
11 estimated to be approximately \$30,000, which is expected
12 to be available from existing sources. It is anticipated
13 that this figure will approximate \$65,000 when the program
14 is fully implemented and in order to accommodate one
15 hundred and ten students. Student fees and other fore-
16 seeable sources of income may produce an additional
17 \$10,000. The remaining \$25,000 will have to be provided
18 from other sources.

19 Unless the Federal university grants are
20 substantially increased, we recommend that special grants
21 for the training of health personnel be provided by the
22 Federal Government.

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1 The Director of the Dalhousie School of
2 Nursing has made a suggestion that there should be further
3 investigations on a type of nursing education known as a
4 Central School of Nursing, which is mentioned in the brief,
5 but it is the feeling of Dalhousie University that while
6 we would give every co-operation to the establishment of
7 the school, that we have not yet sufficient data to enable
8 us to make a specific recommendation. The observations
9 made, however, that Nova Scotia's geography, and the loca-
10 tion of the hospitals in the Province and their size
11 would make this a very suitable area to conduct a Central
12 School of Nursing, perhaps at first only on an experimental
13 basis, and I can repeat what the brief says, that the
14 University would certainly want to give the fullest measure
15 of co-operation if such an experiment could be undertaken
16 jointly with the University or with any other group of
17 hospitals or institutions in the area.

18 At the present time, the finances of the
19 School of Nursing would seem to be in a reasonable balance,
20 but we are not entirely happy that this depends only on
21 the division of the health grants among the four Atlantic
22 Provinces, and if there should be any change in this
23 arrangement, for example, if one Province should withdraw
24 from the scheme, it would require us to completely re-assess
25 our financial picture, and naturally we would like to be
26 assured on a longer term basis of the nature and type of
27 financial support required to keep the School of Nursing
28 operating in a healthy state.

29 The College of Pharmacy is the only other
30 division existing at the present time in the Faculty of



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1 Health Services, and it came to the University, as I said,
2 only this year, so it is not possible to make very accurate
3 predictions since the school has been operated by the
4 University only for a few weeks now. It is interesting
5 to note, however, that it came to the University as a
6 result of a recommendation originated by the pharmacists
7 of the Atlantic Provinces and undertaken by the Canadian
8 Pharmaceutical Association, which recommended that the
9 school should come into Dalhousie University, and for the
10 first time this year students have embarked on a four-year
11 program, the first time this program has been available in
12 the Atlantic Provinces. The enrolment has increased by
13 50%. Again, on the initial arrangements whereby the School
14 of Pharmacy or the College of Pharmacy was taken over by
15 Dalhousie University, the financial arrangements were
16 brought fairly well into balance. It is estimated that it
17 will cost something like \$30,000 for the University to
18 operate the college this year, and after the available
19 sources of student fees, Government grants, including the
20 so-called Massey grants in relation to students on the
21 degree course, it was estimated that a certain sum of
22 money would be required to keep it in balance, and the
23 pharmacists of the area, or really of the Provinces of
24 Nova Scotia and New Brunswick, have subscribed, very
25 generously, a total amount which is now fixed at \$10,500.
26 At the moment, this makes up about one-third of our budget,
27 but it is not anticipated this can be increased, and it is
28 anticipated that when the school reaches the enrolment of
29 1,108, that the budget of the school will more than double,
30 and of this additional amount the University can now only

Health Services, and it came to the University, as I said.



1 see something like \$10,000 additionally available from
2 student's fees and other sources, leaving us in need of
3 something like \$25,000 from sources not presently known
4 or available to us.

5 Finally the submission points out that unless
6 the Federal University grants are substantially increased
7 we recommend the special grants for the training of health
8 personnel, including pharmacists, ought to be provided by
9 the Federal Government, or within some scheme of fitting
10 into the national health program.

11 Those are the only two divisions of the
12 Faculty of Health Professions at the present time. The
13 University has, however, authorized the establishment of a
14 School of Physiotherapy and a School of Occupational
15 Therapy, and these will be established as soon as it is
16 possible to do so. My understanding is that this cannot
17 be done until the requirements of the new medical school
18 have been met, at which time the University will co-operate
19 fully with the Nova Scotia Rehabilitation Centre in these
20 two additional fields, and such others as may be required
21 in the future, for example, the training of medical tech-
22 nicians and perhaps the training of clinical psychologists.
23 Clinical psychologists are now trained, again with the
24 assistance of the health grants, partly in the Faculty of
25 Arts and Sciences and partly in the Faculty of Medicine.

26 I think, Mr. Chairman and Commissioners,
27 that that is a sufficient summary of the presentation of
28 this Faculty for the present time. Both the Director of
29 the School of Nursing and of the College of Pharmacy are
30 here, and can assist in the answering of questions in the

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this Faculty for the present time. Both the Director of

the School of Nursing and of the College of Pharmacy are

...and can assist in the answering of questions to the



1 event you wish to inquire in greater detail.

2 THE CHAIRMAN: Thank you very much. Mr.
3 Hall, have you any questions in amplification?

4 MR. HALL: There are one or two questions
5 I would like to direct to Dr. Stewart. In the first place,
6 can you tell us if you experience any difficulty in
7 acquiring adequate statistics, or statistical and analy-
8 tical information on the aspects of health and health care?
9 I am talking research now mostly.

10 DR. STEWART: I am not quite sure just what
11 type of statistics you have in mind.

12 MR. HALL: Well, any statistics necessary
13 for any research project on the different aspects of health
14 and health care.

15 DR. STEWART: We have some very valuable
16 sources of information through the Hospital Insurance
17 Commission and the Department of Public Health of the
18 Province, and have had excellent co-operation from them.
19 We don't have adequate staff, particularly in our Depart-
20 ment of Preventive Medicine. However, recently we have
21 appointed an additional staff member in the Department of
22 Preventive Medicine, and we hope more work will be done
23 along this line. I am sure we are not making as much use
24 as could be of the information that is available to give
25 us a better picture of the health area.

26 MR. HALL: If the Faculty of Medicine is
27 expanded to the extent that you recommend, will the faci-
28 lities for training in the hospitals still be sufficient
29 for the number of graduates?

30 DR. STEWART: Yes, Mr. Chairman. As I

...ent you wish to inquire in greater detail.

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MR. HALL: Well, any statistics necessary

for any research project on the different aspects of health

DR. STEWART: We have some very valuable

sources of information through the Hospital Insurance

Commission and the Department of Public Health of the

Province, and have had excellent co-operation from them.

We don't have adequate staff, particularly in our Depart-

ment of Preventive Medicine. However, recently we have

Preventive Medicine, and we hope more work will be done

along this line. I am sure we are not making as much use

as could be of the information that is available to give

us a better picture of the health area.

MR. HALL: If the Faculty of Medicine is

expanded to the extent that you recommend, will the fac-
ilities for training in the hospitals still be sufficient

for the number of graduates?

DR. STEWART: Yes, Mr. Hall.



1 mentioned there, it is suggested by the Association of
2 Canadian Medical Colleges that there should be at least
3 10 beds in the affiliated hospitals for each student in
4 the senior year. If we go up to 75 in the senior year,
5 we would have an adequate number of beds by the time the
6 Victoria extension and the Halifax Infirmary are completed
7 and the Rehabilitation Centre which we hope will come in a
8 few years.

9 MR. HALL: On page M-23, you refer to the
10 ratio of persons per physician in Nova Scotia and Canada.
11 Would you, or could you, give us an indication of what you
12 consider an ideal ratio might be?

13 DR. STEWART: This is a very difficult matter
14 Mr. Chairman, as I am sure you know, and I hope that your
15 Commission will be, your research group perhaps can do a
16 little better than maybe we have yet. No, I cannot answer
17 that question specifically. I can point out this fact,
18 that in the Canadian Sickness Survey in 1951 the number of
19 doctors' calls per thousand population in the three Mari-
20 time Provinces, excluding Newfoundland, was somewhere in
21 the neighbourhood of 15,000 in the year for house calls.
22 For insured people, the three largest companies in Canada
23 and the Government-financed plan in the Swift Current area
24 in Saskatchewan, the number of calls was of the order of
25 21 to 22 hundred, which was about 50% above the level in
26 this Province. In Maritime Medical Care however, our own
27 insurance plan, the figure is something like 32. Whether
28 we should aim around 21 or 22 or 32 hundred, if you include
29 all physician services it is 37. I don't think we know
30 enough about what the volume of service will be if you have



mentioned there, it is suggested by the Association of Canadian Medical Colleges that there should be at least 10 beds in the affiliated hospitals for each student in the senior year. If we go up to 75 in the senior year, we would have an adequate number of beds by the time the Victoria extension and the Halifax Infirmary are completed and the Rehabilitation Centre which we hope will come in a few years.

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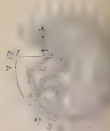
1 the whole population covered. However, those figures
2 would seem to indicate that we either need 50% more
3 doctors, or make the present ones work 50% harder, and
4 most of them think they cannot, they are working hard
5 enough now.

6 MR. HALL: On page 25 and 26 of your section
7 of the brief, you recommend subsidization of doctors in
8 areas below average economic status. Could you give us an
9 indication of what form you think that subsidy should
10 take?

11 DR. STEWART: No, I don't know what amount
12 this should be, and haven't really given that any conside-
13 ration. We are impressed with the fact that there are a
14 few communities in the Province of Nova Scotia which
15 would not have a doctor if the Department of Health were
16 not providing a subsidy to get a doctor to go and practise
17 in that area. It gives him some assured income, but what
18 the amount should be, I have not made any study of, and
19 could not express an opinion.

20 MR. HALL: Then you go on to say that you
21 recommend provision of medical insurance for the indigent
22 would seem to be the two obvious methods. Do you propose
23 any method of payment for the medical insurance? Have you
24 any suggestions or recommendations in that regard?

25 DR. STEWART: I was not sure that as a
26 member of the Faculty of Medicine that I should make any
27 such recommendations in this regard, but as you know, I
28 have had some interest in this in the Department of Health
29 and working with them on their health survey too, and I
30 think that a system that would provide first for the



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MR. HALL: Then you go on to say that you recommend provision of medical insurance for the indigent would seek to be the two obvious methods. Do you propose any method of payment for the medical insurance? Have you any suggestions or recommendations in that regard?

DR. STEWART: I was not sure that as a member of the Faculty of Medicine that I should make any such recommendations in this regard, but as you know, I have had some interest in this in the Department of Health and working with them on their health survey too, and I think that a system that would provide first for the



1 completely indigent of this Province, who are not all
2 covered under the Provincial Welfare Plan, only a small
3 proportion, about eight or nine thousand people are
4 covered by the grants of the Department of Welfare, the
5 services of which are provided through Maritime Medical
6 Care. There are a lot of other people who are receiving
7 welfare credit from the municipalities and Provincial
8 Government, but are not under that plan. These are
9 completely indigent people, who surely should be under the
10 plan first. I am sure there is another group who are
11 medically indigent and cannot afford large bills, and I
12 am sure there should be some system whereby a part, or the
13 whole of their premiums could be covered.

14 MR. HALL: If these two things were imple-
15 mented, the subsidization of doctors in areas below
16 average income status, and the provision of medical insu-
17 rance for the indigent, could you give us an idea of what
18 you think the increase in the demand for medical services
19 would be? I think you said if the entire population were
20 covered, you think it would be 50% increase. Could you
21 relate that increase if these two provisions were made?

22 DR. STEWART: I would be very happy to do
23 some statistical enumerating to see if I could come up
24 with that, but at the moment I could only guess.

25 COMMISSIONER GIRARD: I would like to ask
26 Dr. Hicks to give us more information on the central
27 school plan, and before that I would like to say that
28 since we talked this morning about the shortage of doctors,
29 the shortage of dentists, and the shortage of nurses, I
30 would like also to commend the School of Nursing at



completely indigent of this Province, who are not all covered under the Provincial Welfare Plan, only a small proportion, about eight or nine thousand people are covered by the grants of the Department of Welfare, the services of which are provided through Maritime Medical Bureaus. There are a lot of other people who are receiving services through the Maritime Medical Bureaus, but they are not covered by the Provincial Welfare Plan. I am sure there is another group who are medically indigent and cannot afford large bills, and I am sure there should be some system whereby a part, or the whole of their premiums could be covered.

mentioned, the subsidization of doctors in areas below average income status, and the provision of medical insurance for the indigent, could you give us an idea of what you think the increase in the demand for medical services would be if these two provisions were made? Could you think it would be 50% increase. DR. STEWART: I would be very happy to do

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COMMISSIONER GIRARD: I would like to ask

Dr. Hicks to give us more information on the central

since we talked this morning about the shortage of doctors,

the shortage of dentists, and the shortage of nurses, I

could like also to commend the School of Nursing at



1 Dalhousie University for bringing forth a plan, or a
2 suggestion that may be the answer to some of our shortages
3 in Canada, and so if Miss MacLennan will give us some
4 further information on how the plan for the central school
5 would work.

6 DR. HICKS: I think, Mr. Chairman, that it
7 would be desirable to have Miss MacLennan continue this
8 discussion, and I would before asking her to answer Miss
9 Girard's question, merely say that I would like to empha-
10 size again that the University as yet does not consider
11 that it is in a position to be categorical about this,
12 but we would be very interested to see an experiment under-
13 taken, that we would be happy if your Commission, after it
14 has looked at the situation across Canada, might perhaps
15 make suggestions which would enable something further to
16 be done in this area, and I would like to mention one
17 other thing which is in paragraph H-17 of our submission,
18 and that is that at this stage the inquiries we have made
19 concerning the establishment of a central school plan for
20 training nurses would not involve the discontinuance of
21 existing programs in the Province for training nurses in
22 the hospitals.

23 MISS MacLENNAN: Mr. Chairman and members
24 of the Commission, in the brief of the School of Nursing
25 of the University, on page H-6, I have placed a definition
26 of the central school, which I would like to read at this
27 time: "A central school is one whose administrative and
28 educational personnel are organized so as to constitute
29 an educational entity although the students' clinical
30 experience is secured in more than one hospital and in

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MISS MACLENNAN: Mr. Chairman and members

of the central school, which I would like to read at this

educational personnel are organized as to constitute

an educational entity although the students' clinical



1 other agencies as well." Like Dr. Stewart, I frequently
2 wear different hats than the one I wear as University
3 personnel, and in 1950 I assisted Dr. Stewart in the
4 Medical Services Survey of Nova Scotia in doing the
5 nursing facilities, and in the report of that year I
6 described rather in detail a possible central school
7 pattern for Nova Scotia. In listening to the report of
8 the Department of Health this morning, and having a little
9 foreknowledge of what the hospital construction plans
10 were for Nova Scotia, I did a bit of computation in my
11 head when I was preparing the brief for which I will have
12 another change of hat on Wednesday afternoon when I pre-
13 sent the brief on behalf of the Registered Nurses' Associa-
14 tion of Nova Scotia. That even with this extended bed
15 capacity in Nova Scotia in those hospitals which have
16 schools of nursing, this increased number of beds will not
17 permit a sooner increase in the student body to make up
18 for the additional requirement for graduate nurses, which
19 our statistics which were projected to 1965 only as set
20 forth in what we call locally the Gass Report, prepared
21 for the Hospital Insurance Commission in 1956 and 1959,
22 the 1,200 requirement which was mentioned in this brief.

wear different beds than the one I wear as University personnel, and in 1950 I assisted Dr. Stewart in the Medical Services Survey of Nova Scotia in doing the nursing facilities, and in the report of that year I pattern for Nova Scotia. In listening to the report of the Department of Health this morning, and having a little foreknowledge of what the hospital construction plans were for Nova Scotia, I did a bit of comparison in my head when I was preparing the budget for which I will have another change of hat on Wednesday afternoon when I presented the brief on behalf of the Registered Nurses' Association of Nova Scotia. That even with this extended bed capacity in Nova Scotia in those hospitals which have schools of nursing, this increased number of beds will not permit a sooner increase in the student body to make up for the additional requirement for graduate nurses, which our statistics which were projected to 1965 only as set forth in what we call locally the Gasar Report, prepared for the Hospital Insurance Commission in 1956 and 1959, the 1,200 requirement which was mentioned in this brief.



1 So that our 15 existing schools of nursing in Nova Scotia
2 will not be able to meet our need up to 1965 even with the
3 increased number of beds being built under the hospital
4 construction plan which the Minister of Health this
5 morning said was projected even to 1968. In looking over
6 the remaining some 35 hospitals in Nova Scotia, the only
7 15 schools of nursing, there is a lot of good clinical
8 material in hospitals that will have the bed capacity of
9 between 150 and 200 which should be put into use for the
10 preparation of nurses. In one of the units we consider
11 professionally to be perhaps a little small; in other
12 words, we say very glibly we don't like to see a lot of
13 new small schools being opened, and at the same time we
14 have a responsibility for providing professional personnel.
15 The central school plan has been in operation in various
16 parts of the United States of America for a number of
17 years, so there is some background of data to draw on for
18 experience, and there are two or three ways in which it
19 may be done here, and the reason we have protected our-
20 selves in our own brief, in paragraph 17, is because in
21 the Halifax area where there are five schools there is
22 still room for a central school.

23 At the same time those of you who have not
24 studied the Halifax pattern, three of these five schools
25 are in specialized hospitals whose services technically --
26 or, rather, the clinical facilities should technically be
27 made available for affiliation to technical hospital
28 student nurses. So, if the schools of nursing in the
29 special hospitals were concentrated on the special hospital
30 preparation it leaves us with only two hospitals in the

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student nurses. So, if the schools of nursing in the

special hospitals were concentrated on the special hospital



1 local area having a generalized educational program. So,
2 we could have, first of all, a central school just in
3 Halifax alone. That would not still make any use of the
4 clinical facilities in the Province. So that a second
5 pattern, a central school extended beyond the boundaries
6 of Halifax should not be impractical, and it is in this
7 area that we feel, and perhaps it would be worthwhile
8 thinking out, an experiment to use the facilities of hospi-
9 tals within a 50 or 60-mile radius of Halifax, and where
10 we felt it may be feasible -- not necessarily so -- for
11 the University to offer its services in the lecture level
12 of this program, using the wards of the hospitals of 150
13 and 200-bed capacity within the 60 or 70-mile radius of
14 the City of Halifax. It will take a lot of thinking out:
15 the amount of personnel required, and the costs involved,
16 but very briefly that is the idea behind a central school
17 of nursing.

18 COMMISSIONER GIRARD: Because you wear so
19 many hats, Miss MacLennan, I wonder if you would mind
20 thinking now as representing the Registered Nurses' Associa-
21 tion and answering a question about something that was
22 put forth this morning. I made a note of it at the time,
23 and I am sure you would not mind giving us some information
24 on it. This is along the same lines, because it pertains
25 also to shortage of nurses. There was a statement here
26 from the Government of Nova Scotia brief at page 38 saying
27 that there has been a failure rate of over 40% in registra-
28 tion examinations written in 1960 by student nurses in
29 this Province. Could you give us some information on this
30 high rate of student failures of examinations?

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COMMISSIONER GERRARD: Because you were so

many hats, Miss MacLennan, I wonder if you would mind thinking now as representing the Registered Nurses' Association and I am sure you would not mind giving us some information on it. This is along the same lines, because it pertains also to shortage of nurses. There was a statement here that there has been a failure rate of over 40% in registration examinations written in 1960 by student nurses in this Province. Could you give us some information on this



1 MISS MacLENNAN: Well, what is the prize
2 for answering the 64,000 dollar question? Since -- and I
3 am not sure of my dates -- but I think it is 1954, the
4 Registered Nurses' Association of Nova Scotia has taken
5 part in the State Board Test Pool examination scheme which
6 has headquarters in New York. Eight of the ten provinces
7 in Canada participated in this pool as well as the 51
8 states and territories of the United States. We are not
9 too sure just why the Nova Scotia students are presenting
10 such a high failure rate. However, we have been looking
11 at it over a period of years, and this is the highest
12 rate -- the 1960 rate -- we have experienced; although
13 when it was 22 we were quite concerned a couple of years
14 ago. We think we have some of the answers in the method
15 of teaching and the method of examining in the schools of
16 nursing before they come up for their provincial registra-
17 tion, and the basic difference between the S.R. merit and
18 the State Pool is the objective type of examination based
19 on situational questions. So, a great deal of judgment
20 is involved, and judgment does not respond very well to
21 memorization. We feel there is something in the area of
22 methods of teaching that perhaps accounts for the failure
23 in the examinations. However, from the point of view of
24 the number of persons available for nursing in Nova Scotia,
25 in that 40% is included the student who has failed only
26 in one examination, and she may write that examination
27 over again in the next sitting of the examination and
28 successfully pass. So that the 40% failure of nurses
29 does not mean 40% of any graduating year is lost to the
30 profession. By sitting supplementary examinations they

MISS MacLENNAN: Well, what is the prize

for answering the \$4,000 dollar question? Since -- and I

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1 may remove their deficiency and receive their registration.
2 In the meantime there is a clause in the Registered Nurses'
3 Act of Nova Scotia, and I believe there are similar
4 clauses in the other places across the country, whereby a
5 temporary permit is granted to the student nurse on
6 completion of her school of nursing program; that is when
7 she finishes her hospital examinations and completes her
8 1095 days which the Act requires she put in at the hospi-
9 tal school, and on completion of her 1095 days and success-
10 ful passing of her hospital examinations she may practise
11 on a temporary permit until such time as she writes her
12 State Registered examinations. So that 40% are functioning
13 as general duty nurses. However, that does not solve the
14 problem of why we are having a 40% failure. As it reads
15 it sounds as though they were eliminated from the profes-
16 sion, and that is not so. They are available for work.

17 COMMISSIONER GIRARD: Miss MacLennan, you
18 know the report of the pilot project on accredited schools
19 of nursing in Canada has shown a very high percentage of
20 instructors in schools of nursing in Canada have only a
21 one-year certificate: do you think this has any bearing
22 on the high percentage of failures in schools?

23 MISS MacLENNAN: That is a question that may
24 be double-barrelled. I believe that we can say two things
25 with respect to the standard: if your teachers are not
26 fully qualified, then your students perhaps are not getting
27 the best of instruction, and across Canada the preparation
28 of instructors leaves much to be desired. We have some-
29 thing in the schools across Canada, and a fair proportion
30 in Nova Scotia, of instructors who have not yet had their



in the meantime there is a clause in the Registered Nurses Act of Nova Scotia, and I believe there are similar clauses in the other places across the country, whereby a temporary permit is granted to the student nurse on completion of her school of nursing program; that is when she finishes her hospital examinations and completes her 1095 days which the Act requires she put in on the hospital school, and on completion of her 1095 days and successful passing of her hospital examinations she may practice on a temporary permit until such time as she writes her State Registered examinations. So that 40% are functioning as general duty nurses. However, that does not solve the problem of why we are having a 40% failure. As it regards the standards as though they were eliminated from the program, and that is not so. They are available for work.

COMMISSIONER GENERAL: Miss Malvern, you know the report of the pilot project on certified school of nursing in Canada has shown a very high percentage of instructors in schools of nursing in Canada have only a one-year certificate; do you think this has any bearing on the high percentage of failures in schools?

Miss Malvern: I believe that we can say two things with respect to the standards: if your teachers are not fully qualified, then your students perhaps are not getting the best of instruction, and across Canada the proportion of instructors leaves much to be desired. We have some in the schools across Canada, and a fair proportion



1 special preparation for teaching. Then, the one-year
2 diploma course is an attempt to give them some of the
3 techniques of teaching. That leads us to the next step
4 where the fully qualified instructor would be one who
5 would have that level of education for teaching super-
6 vision and administration. The other thing that bothers
7 us in Nova Scotia is that according to our Act a school
8 of nursing may admit a student who has achieved only her
9 Grade 11 pass certificate from the Department of Education
10 of Nova Scotia. Although many of the schools have set
11 their own standard at complete matriculation, yet we still
12 have a fair number of students entering the schools with
13 a Grade 11 pass certificate which, for the information of
14 those who do not know what that means, is a pass in
15 English and History and any other three subjects from the
16 Grade 11 curriculum which may be Civil Defence, Art,
17 Music, Bookkeeping, Typing -- any three, the way the Act
18 reads. So, there is a certain element of our student
19 body who are not academically competent to handle the
20 examinations.

21 COMMISSIONER BALTZAN: Miss MacLennan, I
22 would like to ask this question: with regard to your
23 central school of nursing, how much time will the beginner
24 spend in the central school of nursing, and from there
25 does she proceed to the clinical areas in a general hospi-
26 tal, and is it divided amongst various specialties in
27 order to complete her curriculum? I would like to be
28 informed about the system behind the new procedure in
29 relation to a central school of nursing.

30 MISS MacLENNAN: There are various patterns



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28 relation to a central school of nursing.



1 which have been used whereby the students would come to
2 the central school for their courses of instruction, say,
3 for the preliminary period which may be three, four or
4 five months. Then they would be assigned to the clinical
5 areas in various hospitals for intermediate -- first of
6 all, for their junior medicine, junior surgery; then they
7 would return to the central school for another period of
8 lectures, and then again go out into the clinical field
9 for junior periods of surgery -- it may be a specialized
10 area such as ear, nose and throat, and so on -- the "block"
11 system, which is the word we use in the profession to
12 describe this, and then return to the classroom and into
13 the clinical field, return to the classroom and into the
14 clinical field. It differs somewhat from the Saskatchewan
15 pattern of a central teaching program which only involves
16 a student going to the central area, University of Saskat-
17 chewan, for preliminary period and then they went to their
18 home school. There are other variations for the administra-
19 tion pattern, and that is the smaller hospitals were iden-
20 tified as the home school, as in Saskatchewan, and then
21 they simply came into the central place for certain
22 teaching. But, in a true central school their home school
23 would be the central school. Miss "X" may be sent to the
24 Halifax Infirmary for medicine and to the Glace Bay
25 General for surgery, and to the Yarmouth Hospital for
26 small rural hospital experience. The student would be a
27 member of the central school and not of any one hospital.
28 The home school is the central school rather than the
29 existing hospital school. Those would be patterns we
30 would have to work out to see which would be most feasible



the central school for their courses of instruction, say, for the preliminary period which may be three, four or five months. Then they would be assigned to the clinical areas in various hospitals for intermediate -- first of all, they would return to the central school for another period of lectures, and then again go out into the clinical field. The system, which is the word we use in the profession to describe this, and then return to the classroom and into the clinical field, return to the classroom and into the clinical field. A student going to the central area, University of Saskatchewan, for preliminary period and then they went to their clinical pattern, and that is the smaller hospitals were then they simply came into the central place for certain teaching. But, in a true central school their home school would be the central school. Miss "X" may be sent to the General for surgery, and to the Yarmouth Hospital for small rural hospital experience. The student would be a member of the central school and not of any one hospital. The home school is the central school rather than the existing hospital school. These would be patterns we



1 for the area.

2 COMMISSIONER BALTZAN: Would these areas
3 you distribute your students to -- would they be in a
4 position to accommodate these people that are farmed out
5 from your central school?

6 MISS MacLENNAN: That is all part of the
7 developing plan to see they did have qualified teachers.
8 Whether the qualified teachers would go from a central
9 school as a visiting pattern, as they do in Saskatchewan,
10 or it may be necessary to have permanent teaching facili-
11 ties in the clinical areas within the 60-mile radius --
12 there are several hospitals that will reach the 200-bed
13 capacity under the hospital construction plan which are
14 contemplating at the moment independent or separate
15 schools of nursing that might well be brought into a
16 central plan to make better use of their 200 beds which
17 they are going to put up.

18 COMMISSIONER BALTZAN: How big should a
19 hospital be before it can provide good training for a
20 school of nursing?

21 MISS MacLENNAN: The latest figures I can
22 quote with any degree of accuracy -- the figure put out
23 by the United States Hospital Studies Commission -- and
24 that is that no hospital with less than 150 beds should
25 contemplate a nurse education program.

26 COMMISSIONER VAN WART: This question I
27 shall direct to Dean Stewart, but if he can't answer it,
28 probably the President can answer it. At page 3, section
29 17, you have provided your sources of funds, and in
30 section 19 you have gone on to ask for grants for



COMMISSIONER BARTON: Would these areas

3 You distribute your students to -- would they be in a
4 position to accommodate these people that are turned out
5 from your central schools?

MISS MacLENNAN: That is all part of the

Whether the qualified teachers would go from a central
9 school as a visiting pattern, as they do in Saskatchewan,
10 or it may be necessary to have permanent teaching facilities
11 also in the clinical areas within the 60-mile radius.

14 contemplating at the moment independent or separate
15 schools of nursing that might well be brought into a
16 central plan to make better use of their 200 beds which
17 they are going to put up.

COMMISSIONER BARTON: How did should a

19 hospital be before it can provide good training for a
20 school of nursing?

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22 quote with any degree of accuracy -- the figure put out
23 by the United States Hospital Studies Commission -- and
24 that is that no hospital with less than 150 beds should
25 contemplate a nurse education program.

27 shall direct to Dean Stewart, but if he can't answer it,
probably the President can answer it. At page 3, section
7. You have provided your sources of funds, and in



1 scholarships or bursaries for students, and in some other
2 sections there are certain specific references for some
3 Federal monies. Taking the whole picture in large, would
4 you consider a 33% grant by the Federal Government, 33 by
5 the Provincial Governments and 33 by tuition, philanthropy
6 and so on, fair distribution of the monies coming to a
7 University to be applied to the various segments?

8 DR. STEWART: I think I would have to do a
9 little figuring on just what means, but some formula of
10 sharing would probably have to be worked out. I am not
11 at all sure of what the proportion should be, but in
12 principle I think that there is a case to be made for
13 Federal support, (a) because of the very large part in
14 the building cost which is for research, and (b) because
15 of the fact that one-third of our Dalhousie graduate
16 school go to other parts of Canada, and two-thirds stay
17 in the Atlantic Provinces. There are, I am sure, other
18 reasons we might feel we have a claim for Federal assis-
19 tance. Whether it should be one-third of the total I am
20 afraid I would want to consider a little further.

21 DR. KERR: May I ask whether you are contem-
22 plating an increase in tuition fees from 17.4% to 33?
23 That would be doubling it.

24 COMMISSIONER VAN WART: Well, in that 33
25 there would be tuition fees or grants from philanthropy
26 and your other sources of University revenue; they would
27 all come into the 33.1/3%. The other would be one-third
28 Provincial and one-third Federal -- whether you consider
29 that a fair distribution of monies for these purposes?

30 DR. KERR: I would be reluctant to see us

scholarships or bursaries for students, and in some other sections there are certain grants or bursaries for students. You consider a 33 1/3 grant by the Federal Government, 33 by the Provincial Governments and 33 by tuition, philanthropy and so on, fair distribution of the monies coming to a University to be applied to the various segments?

DR. STEWART: I think I would have to do a little figuring on just what means, but some formula of sharing would probably have to be worked out. I am not at all sure of what the proposal should be, but in principle I think that there is a case to be made for Federal support, (a) because of the very large part in the total of the fact that one-third of our bachelors graduate in the Atlantic Provinces. There are, I am sure, other things. Whether it should be one-third of the total I am afraid I would want to consider a little further.

COMMISSIONER VAN WART: Well, in that 33 there would be tuition fees or grants from philanthropy and your other sources of University revenue; they would all come into the 33 1/3. The other would be one-third Provincial and one-third Federal -- whether you consider that a fair distribution of monies for these purposes?



1 increase the tuition fees to any extent that would shut
2 out students who would make doctors but who haven't the
3 financial means.

4 COMMISSIONER VAN WART: May I ask, have you
5 any breakdown on what the percentages of your revenues
6 for tuition fees, benefactors, and so on, and endowments,
7 etc., would be? I think with the 33.1/3% it would not be
8 necessary to increase your tuition fee. I think you will
9 find those revenues are around 33.1/3, and it is a question
10 of lightening the financial load on the Province and
11 increasing the Federal load, and the reason I asked the
12 question is to find out whether that would be a fair
13 distribution. I would like to find that out if you can
14 look into that.

15 DR. KERR: Yes.

16 COMMISSIONER VAN WART: The second question
17 I want to ask is more for information. Dean Stewart said
18 that he thought they might have to lengthen the academic
19 year and in doing this it would shorten the period in
20 which the student could earn so as to pay for his course.
21 Well, as I understand, in Pittsburgh they have a scheme
22 which is in operation in the Universities and the principle
23 is that their capital plant would be used twelve months
24 of the year instead of seven or eight as at present, and
25 also it allows the student a longer time to get out and
26 earn money so he can pay his way through college. That
27 is under the trimester system of education, and I was
28 wondering if the trimester system of education was
29 brought in vogue it would not be meeting the problem of
30 the student able to earn more money and able to carry on



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2 out students who would make doctors but who haven't the
3 financial means.
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5 COMMISSIONER VAN WART: May I ask, have you
6 any breakdown on what the percentages of your revenues
7 from tuition fees, benefactions, and so on, and endowments,
8 etc., would be? I think with the 33.1% it would not be
9 necessary to increase your tuition fee. I think you will
10 find those revenues are around 33.1%, and it is a question
11 of lightening the financial load on the Province and
12 increasing the Federal load, and the reason I asked the
13 question is to find out whether that would be a fair
14 distribution. I would like to find that out if you can
15 look into that.
16
17 DR. KENNEDY: Yes.
18
19 COMMISSIONER VAN WART: The second question
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28 also it allows the student a longer time to get one and
29 earn money so he can pay his way through college. That
30 is under the trimester system of education, and I was
31 wondering if the trimester system of education was
32 brought in before it would not be meeting the problem of



1 his education.

2 DR. STEWART: Mr. Chairman, we operate our
3 medical school on three terms now, but I think Dr. Van
4 Wart is referring to a system where the student could come
5 in any three of the four three-month periods during the
6 year.

7 COMMISSIONER VAN WART: Yes, that is right.

8 DR. STEWART: This would be almost an
9 impossible situation unless we doubled or perhaps tripled
10 our staff. I attended one medical school where this was
11 done, and I wondered why all the staff were not under the
12 care of psychiatrists. What would happen is that you
13 would start a class in September in anatomy, and the
14 professor would have another class come in three months
15 later, and would start on another one three months later,
16 and if it is a one-year course in anatomy it means he is
17 trying -- it is worse than the Troika: he has four. We
18 feel, however, we don't make use in most universities of
19 the plant to the best of our ability perhaps, and this
20 again is because of shortage of staff.

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1 But if we had support for students at the
2 level of \$2,000 - medical students are now spending about
3 \$2,000 a year; if they were to spend two months longer at
4 school it would have to be of the order of \$2,000 - we
5 would have to have about one-third increase in staff and
6 we would still have our staff teaching three terms, but
7 they would rotate so that each one would have one three-
8 month period for research. This is the weakness of the
9 system which you mentioned which is in operation in
10 Tennessee; you can't get staff to stay unless there is
11 some time for research.

12 THE CHAIRMAN: Just on that particular point
13 of the students, what do you say of the pre-graduation
14 protege plan, where the student would go out with the
15 doctor?

16 DR. STEWART: I don't think this would be a
17 good system of medical education. The student spends two
18 years in the basic sciences and the next year he learns
19 something about the clinical subjects, and then about the
20 fourth year he tests his knowledge in specific problems,
21 he has to think of specific problems to think through the
22 diagnostic problems. It is not a matter of techniques,
23 it is a matter of thinking and reasoning to take responsi-
24 bility. This comes where a man is a member of a clinical
25 team. He starts at the lowest level, but he is given
26 gradual responsibility.

27 COMMISSIONER FIRESTONE: Mr. Chairman, I
28 would like to address three questions to Dr. Kerr, if I
29 may. You have given the Commission a rather impressive
30 story of providing additional training facilities,



But if we had support for students at the level of \$2,000 - medical students are now spending about \$2,000 - we school it would have to be of the order of \$2,000 - we would have to have about one-third increase in staff and we would still have our staff teaching three terms, but they would rotate so that each one would have one three-month period for research. This is the weakness of the system which you mentioned which is in operation in Tennessee; you can't get staff to stay unless there is

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would like to address three questions to Dr. Kemp, if I



1 providing health personnel in all fields. The brief also
2 points out that there is a great need to improve these
3 facilities and to provide additional scholarships, fellow-
4 ships, etc. Would it be possible for the University to
5 add up all the financial expenditures involved as
6 contained in the brief and let us see how much money would
7 be involved in terms of a capital budget and in terms of
8 an operative budget covering the next ten years? I would
9 like to call your attention to paragraph (i) of the Terms
10 of Reference, which states: "The methods of financing any
11 new or extended programs which may be recommended".
12 Therefore we would require not only an estimate of all the
13 recommendations you have made but also suggestions from
14 you as to where the money is going to come to pay for it.

15 DR. KERR: I would be very glad to do that,
16 sir. We would be glad as far as we can, to answer those
17 questions.

18 COMMISSIONER FIRESTONE: You presumably
19 would have some views, and we would like to obtain it.
20 The Commission is seeking those views. Would it be
21 reasonable to expect those views?

22 DR. KERR: It is entirely reasonable, and
23 we would be happy to do it.

24 COMMISSIONER FIRESTONE: My next question
25 refers to F-8 on page F-2, where you speak of the diffi-
26 culties which Dalhousie University has had in obtaining
27 grants from the Provincial Governments because no inter-
28 Provincial arrangement for the sharing of costs exists and
29 this uncertainty impedes the planning you have to do.
30 Have you any proposals to make as to how this uncertainty

ships, etc. Would it be possible for the University to

add up all the financial expenditures involved as

contained in the brief and let us see how much money would

be involved in terms of a capital budget and in terms of

an operative budget covering the next ten years? I would

like to call your attention to paragraph (4) of the Terms

of Reference, which states: "The methods of financing any

new or extended programs which may be recommended".

Therefore we would require not only an estimate of all the

recommendations you have made but also suggestions from

you as to where the money is going to come to pay for it.

DR. KERR: I would be very glad to do that.

We would be glad as far as we can, to answer those

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Provincial arrangement for the sharing of costs exists and

this uncertainty impedes the planning you have to do.



1 can be reduced, and may I suggest that this answer may be
2 included in the submission that you wish to make at a
3 later stage?

4 DR. KERR: I would be very happy to do that.
5 Our hope was that we could get the four Provinces each to
6 take its calculated share of the cost, and two of them
7 have done it, the third is unable to do it all but would
8 like to do it and has moved in the direction we have
9 suggested, and the fourth has a Royal Commission which is
10 going to study it very shortly. Our thought, and has been
11 for some years, is that we would have an inter-Provincial
12 arrangement, and I don't think that we have ever got
13 beyond that proposal.

14 COMMISSIONER FIRESTONE: Thank you. The
15 next question is F-18, F-5. You speak of "The large
16 additional sums required for capital and operation cannot
17 be provided unless a much greater proportion is borne by
18 Government". My question is: would it be possible for you
19 in the subsequent written submission you will be making to
20 us to suggest a formula as to how this could be done?

21 DR. KERR: Yes, indeed, we would be very
22 happy to do that.

23 COMMISSIONER FIRESTONE: Fine. I have one
24 more question, and it is addressed to Dean Stewart, if I
25 may. I am referring to paragraph 19-F of your summary
26 on page 4. You say that plans for the extension of health
27 services should be preceded by a realistic estimate of
28 personnel requirements, and you suggest it would take at
29 least 10 years before any extensive increase in health
30 services can be commenced in the Atlantic region, and you

can be reduced, and may I suggest that this answer may be included in the submission that you wish to make at a

DR. KERR: I would be very happy to do that.
Our hope was that we could get the four Provinces each to take its calculated share of the cost, and two of them have done it, the third is unable to do it all but would like to do it and has moved in the direction we have suggested, and the fourth has a Royal Commission which is going to study it very shortly. Our thought, and has been for some years, is that we would have an inter-Provincial arrangement, and I don't think that we have ever got beyond that proposal.

COMMISSIONER FURBER: Thank you. The next question is F-18, F-5. You speak of "the large additional sums required for capital and operation cannot be provided unless a much greater proportion is borne by Government". My question is: would it be possible for you in the subsequent written submission you will be making to us to suggest a formula as to how this could be done?

DR. KERR: Yes, indeed, we would be very

happy to do that.

COMMISSIONER FURBER: Fine. I have one more question, and it is addressed to Dean Stewart, if I may. I am referring to paragraph 19-B of your summary on page 4. You say that plans for the extension of health services should be preceded by a realistic estimate of personnel requirements, and you suggest it would take at least 10 years before any extensive increase in health



1 provide a great deal more detail in paragraph 40 on this
2 point. I have examined the paragraph 40, and I think
3 your evidence is very convincing, sir. In fact, you also
4 suggest that your estimate would be rather on the conser-
5 vative side. I have gone further and I have looked at
6 paragraph D71, which suggests that it may take 20 years
7 until the Atlantic region is able to obtain a ratio of
8 dentists which is close to the Canadian average. In
9 other words, we are talking about a period of 10 to 20
10 years until we have health personnel in the Atlantic
11 region when improved health services be made available to
12 the people of the Atlantic region to any significant
13 extent. Let's assume that the people of the Atlantic
14 region wish to have a significant improvement in the health
15 services sooner than 10 to 20 years. Can you and your
16 colleagues in dentistry and other sectors of the University
17 think of some proposals which would telescope the provision
18 of the trained man that the Atlantic Provinces may require
19 if we are to have improved services in the Atlantic region,
20 and can this answer be put in the written submission,
21 because it requires a great deal of thought, although you
22 may wish to answer it now. But in terms of trying to
23 provide additional health services, you are quite right in
24 saying you have to have the men to do it. Is there any-
25 thing that can be done which can suggest to you the provi-
26 sion and training of these men?

27 DR. STEWART: We would be very happy to
28 expand on this in any further presentation. I don't
29 think there is any real short-cut to this that is going
30 to help the situation tremendously, and I think it is one



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 saying you have to have the men to do it. Is there any-
 tion and training of these men?

DR. STEWART: We would be very happy to

think there is any real short-cut to this that is going



1 of facts of health we have to face.

2 If I may, sir, just mention something which
3 has bothered me a great deal personally. I was a member
4 of the team that did the survey in Nova Scotia with the
5 Provincial Department of Health in 1948 when the first
6 Federal health grants were made, one of which was to
7 provide a plan for the development of health services.
8 In that survey we showed how many hospital beds would be
9 needed if a hospital insurance plan came in. We can make
10 an estimate of what the needs may be, but unless the
11 machinery is provided to meet this demand well in advance
12 and the demand is then increased, then we are faced with
13 an almost insoluble problem at the time the insurance
14 comes into effect. It was mentioned it would be 1968
15 before we would have the beds we needed, but the provision
16 was not made in 1948. We can build hospital beds much
17 more quickly than we can train a doctor; and this is, I
18 think, a legitimate point to make, that it may take 15
19 years or it may take 20 years to provide the increased
20 volume in trained men which would be required under an
21 insurance plan. What I was talking about would be the
22 demand for services under a complete hospital insurance
23 plan. I think we can meet most of the pressing needs
24 before that time, and I think this is the crucial point.
25 We have suggested one thing. We think that if we could
26 get enough support for medical students that they didn't
27 have to earn part of their educational costs during the
28 summer, and if we could increase the staff at the medical
29 school by one-third we might be able to do in three aca-
30 demic years what we could do in four calendar years.



of facts of health we have to face.

10 I think, also, that we must recognize that
11 the situation is a very real one. I was a member
12 of the committee that was set up in 1968 to study
13 the problem of health care in the United States.
14 I think that the situation is very serious, and
15 it is not only a problem of health care, but
16 it is a problem of the health care system.
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18 it is not only a problem of health care, but
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1 COMMISSIONER FIRESTONE: Would you mind
2 including in your written submission perhaps an answer to
3 the question whether you would be in favour of increasing
4 the flow of immigrant doctors from abroad, assuming that
5 they are well-qualified, on a temporary basis to help
6 deal with some of the shortage until we have an adequate
7 number of doctors trained through your own local facilities?

8 DR. STEWART: We will certainly do that, sir.
9 I have some definite ideas on it, and I shall expand on
10 it further.

11 COMMISSIONER BALTZAN: Mr. Chairman, may I
12 at this moment speak to Dean Stewart? I must say, Dean
13 Stewart, that you have been probably the most cheerful
14 note we have heard up to now. Certainly the number of
15 students in the Atlantic Provinces seeking medical training
16 has increased in the last two years, whereas there has
17 been a progressive decline here and south of us since 1954,
18 and you also declare there has been no decline in the
19 calibre of our medical students, where other schools have
20 had to reduce their standards of admission, etc. I
21 recognize the high calibre, but is there any other secret,
22 where the trend is a little bit different than it is in
23 other places?

24 DR. STEWART: I think it is a misinterpre-
25 tation of statistics, and I am a trained statistician
26 myself. There was a report from the United States some
27 years ago which said that only half as many good students
28 were entering medical schools, and they took 1945 to 1950
29 as a base. Now, anyone knows that in that time only
30 veterans got into school, and from 1950 to 1954 the bright

COMMISSIONER FIRESTONE: Would you mind

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as a base. Now, anyone knows that in that time only



1 boys knew they could get their B.Sc. and then go into
2 medical school. I think everybody at the end of that time
3 looks back and says 36% of the students had Grade A, and
4 now it is 18%. I was never pessimistic about it at all.

5 COMMISSIONER BALTZAN: You suggest that the
6 Government of Canada provides scholarships and bursaries
7 for medical students at a rate of \$2,000 per year. Is
8 that a blanket thing or those who need to be subsidized?

9 DR. STEWART: If we were to run eleven
10 months of the year I think it would have to cover everyone.
11 It is the one that needs the money that would have to be
12 taken care of. Almost any student now who decides at the
13 end of his third year in sciences that he is going to get
14 a degree in sciences - and our students have to spend
15 almost \$2,000 a year - at the end of three years or four
16 years in a medical course there is a differential of about
17 \$12,000. It is one reason we are not getting them. I
18 think if the Government of Canada wants to provide as
19 quickly as possible the additional medical staff that
20 would be necessary before any insurance plan were intro-
21 duced, it would have to provide this sort of thing for
22 every student. If they want to move more slowly it
23 should perhaps be on the basis of need.

24 COMMISSIONER BALTZAN: One other thing, that
25 the plan for the extension of health services be preceded
26 by a realistic estimate of personnel requirements so as to
27 provide him with an income later on. I think that question
28 has been asked before. I will go to the other one: "That
29 any recommendation of the Commission relating to medical
30 education permit free choice of the University as to

COMMISSIONER BARTON: You suggest that the

for medical students at a rate of \$2,000 per year. Is

that a blanket thing or those who need to be subsidized?

DR. STEWART: If we were to run eleven

months of the year I think it would have to cover everyone.

It is the one that needs the money that would have to be

taken care of. Almost any student now who decides at the

end of his third year in sciences that he is going to get

a degree in sciences - and our students have to spend

years in a medical course there is a differential of about

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has been asked before. I will go to the other one: "That



1 whether or not it retains supervision over the year of
2 internship". Would you prefer that this thing be standar-
3 dized or would you prefer to have a local autonomy in
4 your internship?

5 DR. STEWART: We prefer to have local auto-
6 nomy. We don't want to follow the practice of the rest
7 of the country. The fifth-year internship is an important
8 year, and it is one in which he is required to get his
9 licence, and we feel that that is better than turning the
10 man loose to get his training anywhere he wants.

11 COMMISSIONER BALTZAN: Thank you.

12 THE CHAIRMAN: Thank you very much, President
13 Kerr and gentlemen. I think the Commission would want me
14 to thank you for the very great consideration which was
15 given to the preparation of this brief on behalf of the
16 University of Dalhousie, and it is going to be of great
17 assistance to the Commission, and we rely, of course, on
18 having that further information which will become available
19 as and when you are able to deal with it and send it in to
20 the Secretary.

21 DR. KERR: We appreciate your courtesy very
22 much, sir.

23 THE CHAIRMAN: The submission has been
24 filed as an exhibit?

25 MR. HALL: Exhibit 4, sir.

26
27 --- EXHIBIT NO. 4: Submission of Dalhousie University
28
29
30

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SUBMISSION OF THE PROVINCIAL MEDICAL BOARD

OF NOVA SCOTIA

Appearances: Dr. J.R. MacNeil, M.D.
Dr. M.R. Macdonald, M.D.

DR. MacNEIL: On behalf of the Medical Board,
I wish to join the others in wishing you a very high
welcome, and in assuring you of the co-operation of the
Provincial Medical Board in your deliberations.

Our brief is short, and it has been compiled
by Dr. Macdonald, our Registrar, and with your permission
I would ask him to summarize.

THE CHAIRMAN: Very well, Dr. MacNeil.

DR. MACDONALD: The purpose of this submission is to supply pertinent information regarding the
standards for medical education and requirements for
registration for medical practice in Nova Scotia.

Tables are appended showing the number of
physicians presently registered and residing in Nova Scotia,
with some information provided regarding the schools of
graduation of these physicians.

An opinion is expressed concerning the need
to maintain a high standard of medical education and of
medical practice to meet future needs of the people in
Nova Scotia.

--- EXHIBIT NO. 5: Submission of The Provincial Medical
Board of Nova Scotia.

Nova Scotia.

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OF NOVA SCOTIA

SUBMISSION OF THE PROVINCIAL



SUBMISSION OF
THE PROVINCIAL MEDICAL BOARD OF
NOVA SCOTIA

Appearances:

John R. Macneil, M.D.	President
M. R. Macdonald, M.D.	Registrar-Secretary- Treasurer

Summary

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2. Tables are appended showing the number of physicians presently registered and residing in Nova Scotia, with some information provided regarding the schools of graduation of these physicians.

3. An opinion is expressed concerning the need to maintain a high standard of medical education and of medical practice to meet future needs of the people in Nova Scotia.

Introduction

4. The Provincial Board of Nova Scotia extends a cordial welcome to the members of the Royal Commission on Health Services on the occasion of your visit to Nova Scotia.

5. The Provincial Medical Board of Nova Scotia is incorporated under the provisions of Chapter 172, R.S., N.S., 1954 - "The Medical Act of Nova Scotia."

SUBMISSION OF

Appendices:

registrars-georg
Incarcerator

1. The purpose of this submission is to supply pertinent information regarding the standards for medical education and requirements for registration for medical practice in Nova Scotia.
2. Tables are appended showing the number of physicians presently registered and residing in Nova Scotia, with some information provided regarding the schools of graduation of these physicians.
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1 The Board is entrusted with the administration of the
2 Medical Act.

3
4 History

5 6. Legislation bearing upon medical education
6 and licensure of qualified practitioners of medicine in
7 Nova Scotia dates from May 29, 1828, when the House
8 of Assembly passed "An Act to exclude ignorant and un-
9 skilled persons from the practice of Physic and
10 Surgery". (9 George IV. Chapter 5). The title de-
11 notes its significance. On March 30, 1829, an
12 amending Act (10 George IV. Chapter 10) was passed
13 removing the application of the Act of the preceding
14 year from practitioners who had been resident and in
15 practice in the province for seven years before it was
16 passed.

17 7. The next Act was passed on March 17, 1847
18 (10 Vict. Chapter 21). This in essence was a con-
19 solidation of the Acts of 1828 and 1829.

20 8. In 1851 (Rev. Stat. First Series) there
21 is a reference to "Regulations Concerning the Practice
22 of Physic and Surgery", but no actual change in legis-
23 lation.

24 9. In 1856 (Chap. 18, R.S., N.S.), "An Act
25 to regulate the practice of Physic and Surgery" was
26 passed, repealing former legislation, and now providing
27 for (A) registration with the provincial secretary,
28 (B) recovery of fees by registered persons, (C)
29 physicians practicing in the province before 1822, to
30 be licensed without examination, (D) provincial

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History

6. Legislation bearing upon medical education and licensure of qualified practitioners of medicine in the Province of Ontario was passed by the Legislature of the Province of Ontario in 1827. An Act to exclude ignorant and unskilled persons from the practice of Physic and Surgery". (9 George IV. Chapter 2). The title does not fully express the scope and purpose of the Act. On March 30, 1829, an amending Act (10 George IV. Chapter 10) was passed removing the application of the Act of the preceding year from practitioners who had been resident and in practice in the Province for seven years before it was passed.
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1 medical appointments to be held only by physicians
2 duly registered, (E) certificates of registration to be
3 received in evidence, and (F) a penalty of 5 pounds
4 for failing to register.

5 10. Chapter 57, R.S., N.S., 1858 and Chapter 56,
6 R.S., N.S., 1864 did not make any essential changes.

7 11. This was the situation when on April 18,
8 1872, Chapter 31 (R.S., N.S.) "An Act to regulate the
9 qualifications of practitioners in Medicine and Surgery",
10 passed the legislature. Under it the Provincial
11 Medical Board was created, consisting of nine members,
12 five appointed by the Governor in Council and four by
13 the Medical Society of Nova Scotia. Provision was
14 made for a medical register and its annual publication.
15 A course of study prerequisite to examination was required
16 and examiners for candidates seeking a licence was pro-
17 vided. Registration was compulsory and a penalty of
18 \$20.00 a day was set for those who practised without
19 registration.

20 12. In 1873 (Chapter 28, R.S., N.S.) the Medical
21 Act appears unchanged, and in 1877, 1880 and in 1881
22 only minor amendments were made.

23 13. In 1884 (Chapter 24, R.S., N.S.) the member-
24 ship of the Board was increased from nine to thirteen,
25 in the relation of seven to six, appointed on the same
26 basis as the original Board. Powers of the Board were
27 increased, as well as the registration fee.

28 14. In 1886, 1889 and 1891 slight changes were
29 made by Act or Order in Council dealing with preliminary
30 education of medical students and the medical curriculum.

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1 15. Anticipating by many years the Canada Medical
2 Act and the interprovincial reciprocity granted by the
3 Medical Council of Canada (1911), the Maritime Pro-
4 vinces made a reciprocal arrangement in 1895, which
5 in Nova Scotia was covered by rewording Section 9 of the
6 Act, covered by an order in council dated September
7 13, 1895. Later Manitoba joined the Maritime Province
8 group, as did Quebec for a time.

9 16. The first meeting of the Provincial Medical
10 Board was held in Province House, July 24, 1872. The
11 first Medical Register was published in the Royal
12 Gazette, August 1873.

13 17. From the foregoing it will be seen that the
14 medical profession in Nova Scotia followed two impor-
15 tant highways, parallel but often linking.

16 18. The Medical Society of Nova Scotia looked
17 after the needs of the duly qualified registered prac-
18 titioner. It provided for the enlargement of his
19 knowledge and experience by scientific meetings and
20 publications; it tried to assist him in the economic
21 aspects of practice and it assisted in providing help-
22 ful communication and better relations of physicians
23 with their fellows.

24 19. The Provincial Medical Board has dealt with
25 problems of education and licensure, as well as dis-
26 cipline of its registrants.

27 20. Each has supported the other in maintaining
28 high standards of professional qualifications for
29 licensure, and adequate and ethical standards of
30 practice.



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21. The organized teaching of medicine has gone on in Halifax since 1868. It was carried on first by Dalhousie, then by the Halifax Medical College in affiliation with Dalhousie, and since 1911 by Dalhousie once more. It has received continuous and strong support academically from the Provincial Medical Board. Mutual interests in creating and continuing high standards for professional qualification have resulted in continuous and meaningful co-operation throughout the years.

22. At the present time the Provincial Medical Board of Nova Scotia consists of thirteen members, seven of whom are appointed by the Government of Nova Scotia, and six by the Medical Society of Nova Scotia.

Objectives of the Provincial Medical Board of Nova Scotia

23. (1) Setting up and maintenance of the standards for medical education.

24. (2) Registration of physicians for medical practice in Nova Scotia.

25. (3) Discipline of members of the medical profession in Nova Scotia.

Standards for Medical Education

26. The standards for medical education and the qualifications for the practice of medicine in Nova Scotia are set down in The Medical Act of Nova Scotia (Chapter 72, R.S., N.S., 1954). (Appendix A - attached).

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(Chapter 72, R.S., N.S., 1954). (Appendix A -

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27. Briefly, The Medical Act requires a satisfactory educational background, consisting of at least three (3) years pre-medical education following completion of high school studies, then five (5) years of education in a recognized medical school, the last year of which is spent in a clinical internship in a hospital approved for internship by the Provincial Medical Board.

Registration of Physicians

28. In Nova Scotia, following completion of a course in medical education in a recognized medical school, and after satisfying the Board as to other requisites, e.g. character, identification, etc., a medical doctor may be registered for practice in any one of three (3) ways:

29. (1) By passing the examinations of the Provincial Medical Board of Nova Scotia.

30. Students attending Dalhousie University Medical School sit for the conjoint examinations of the university and the Board in their final years.

31. Foreign medical students may be granted permission to sit for these examinations providing credentials presented show that their medical education meets the requirements of the Medical Act, and that they have completed a satisfactory rotating internship in an approved hospital.

32. (2) By passing the examinations of the Medical Council of Canada.

33. Students at all Canadian medical schools have the opportunity of taking these examinations

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tion meets the requirements of the Medical Act, and
that they have completed a satisfactory rotating

internship in a hospital.

- 32. (2) By passing the examinations of

33. Students at all Canadian medical

1 conjointly with their university examinations, but
2 they must present an enabling certificate from one
3 of the provincial licensing authorities.

4 34. Foreign medical graduates must also
5 apply to one of the provincial licensing authorities
6 for an enabling certificate to sit these examinations.

7 35. In Nova Scotia, before granting such
8 an enabling certificate, the registrar must satisfy
9 himself that the applicant's medical education has
10 been satisfactory and that a satisfactory rotating
11 internship in an approved hospital in Nova Scotia
12 has been completed. (The only exception is that
13 British subjects may serve the internship in an
14 approved hospital outside of Nova Scotia).

15 36. The purpose of this "internship in
16 Nova Scotia" requirement is to ensure that the candi-
17 date is a bona fide medical graduate, that qualified
18 registered physicians in Nova Scotia have a chance to
19 observe, oversee and approve of his work in the care
20 of patients and so determine that the candidate is a
21 satisfactory person to hold the registration of the
22 Board, and ultimately engage in the practice of
23 medicine in Nova Scotia.

24 37. (3) By virtue of the reciprocity
25 existing between the Provincial Medical
26 Board and the General Medical Council
27 of the United Kingdom.

28 38. A physician who holds the registration
29 of the General Medical Council may be granted
30 registration in Nova Scotia without further examina-

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39. The General Medical Council of the United Kingdom maintains three (3) separate registration lists, viz:

40. (A) The General List - containing the names of medical practitioners registered by the Branch Councils of England and Wales, Scotland and Ireland.

41. (B) The Commonwealth List - containing the names of medical practitioners who are fully registered by virtue of recognized qualifications granted in Commonwealth countries.

42. (C) The Foreign List - containing the names of medical practitioners who are fully registered by virtue of recognized qualifications granted in foreign countries - presently Rangoon Medical College, in Burma is the only recognized medical school on the foreign list.

43. The reciprocity of the Provincial Medical Board extends to all three (3) lists. Of five (5) other provincial licensing authorities in Canada who have reciprocity with the General Medical Council, this extends to the general list only, with one possible exception, which recognizes the Commonwealth list also.

44. Subsequent tables will show the numbers of doctors registering in Nova Scotia, by virtue of this reciprocity.



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1 The Present and Future Requirements of
2 Personnel to Provide Health Services

3 45. (See (D) - Terms of Reference of the
4 Royal Commission on Health Services.)

5 46. Tables are appended showing the number
6 of physicians registered and practicing in Nova Scotia
7 at the present time. Table No.1 shows that there are
8 809 physicians registered and residing in Nova Scotia
9 (June 30, 1961), which would appear to give a gross
10 physician-population ratio of 1:900. (Population
11 figure 728, 347, D.B.S. data December 31, 1960).

12 47. However, when the doctors who are in
13 military service, in administration, post graduate
14 training, etc. are deducted, the total number of
15 doctors in active medical practice giving personal
16 medical care is only 597 and the physician-population
17 ratio becomes 1:1220.

18 48. Table No. 2 shows the number of
19 physicians doing a specialty practice in Nova Scotia.
20 This represents 212 of the 809 total physician popula-
21 tion.

22 49. It is not proposed at this time to
23 attempt to estimate the future requirements for
24 additional doctors to meet any increased demand for
25 medical services. A survey of the utilization of
26 medical manpower in Nova Scotia is presently being
27 done by the Medical Society of Nova Scotia and these
28 results will be submitted at a later date.

29 Methods of Providing adequate personnel with the best
30 possible training and qualifications for health services

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Methods of providing adequate personnel with the best



Royal Commission on Health Services).

51. If a system of health insurance were introduced in Nova Scotia, in all probability a substantial increase in medical manpower in Nova Scotia would be required. This increase could come from three (3) sources:

52. (1) The Canadian Medical Schools, particularly Dalhousie would have to increase their enrolments substantially.

53. (2) More physicians holding registration with the General Medical Council, could immigrate since registration in Nova Scotia would be comparatively easy, because of the reciprocity agreement.

54. (3) More foreign medical graduates.

55. Number (1) above requires no elaboration in this submission, as no doubt it will be adequately dealt with by others.

56. Regarding number (2) - Table 3 (appended) shows the total number of new registrants in Nova Scotia in the years 1951 and 1961, and the number registered through reciprocity with the General Medical Council.

57. It is interesting to note that of the 10 registering in 1951, by reciprocity, all entered practice in Nova Scotia, but in 1961, of 34 registering by reciprocity only 9 entered practice in Nova Scotia.

58. The purpose of registration in Nova



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3 bility to write the Medical Council of Canada examina-
4 tions and go elsewhere in Canada, when successful,
5 (b) employment in military or federal government
6 service, a requirement of which is the holding of
7 registration in one province of Canada, (c) post-
8 graduate training or certification as a specialist, which
9 also requires possession of a provincial registra-
10 tion.

11 59. Regarding (3) - foreign medical graduates.

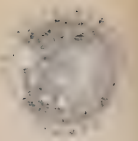
12 For the past several years the influx of
13 foreign medical graduates into Canada has posed a most
14 difficult problem for licensing authorities and hos-
15 pitals.

16 60. While the language barrier has been a
17 problem, the equating of their medical education with
18 Canadian Medical education has been a more difficult one.

19 61. There is no recognized medical body in
20 Canada, or the United States, for assessing the standards
21 of medical education in foreign medical schools and
22 consequently the responsibility devolves upon each
23 provincial licensing authority to satisfy themselves
24 that a foreign medical graduate is a suitably trained
25 candidate for registration for the practice of medicine.

26 62. The assessment of these foreign medical
27 graduates has been approached in a variety of ways, by
28 various licensing authorities in Canada and the United
29 States - some of these methods are as follows:

30 63. (1) Basic Science Examinations.



Scots for other registrants of the General Medical Council were (a) to obtain a certificate of eligibility to write the Medical Council of Canada examinations and go elsewhere in Canada, when successful, (b) employment in military or Federal Government registration in one province of Canada, (c) post-graduate training or certification as a specialist, which also requires possession of a provincial registration.

59. Regarding (3) - foreign medical graduates. For the past several years the influx of foreign medical graduates into Canada has posed a most difficult problem for licensing authorities and hospitals.

60. While the language barrier has been a problem, the educating of their medical education with Canadian Medical education has been a more difficult one. 61. There is no recognized medical body in

Canada, or the United States, for assessing the standards of medical education in foreign medical schools and consequently the responsibility devolves upon each

that a foreign medical graduate is a suitably trained candidate for registration for the practice of medicine. 62. The assessment of these foreign medical

various licensing authorities in Canada and the United States - some of these methods are as follows:

63. (1) Basic Science Examinations.



1 Applicants are required to sit examinations, set by
2 members of Medical School faculties, in certain sub-
3 jects, such as anatomy, biochemistry, physiology,
4 pathology, bacteriology and pharmacology. Usually
5 an examination to determine what knowledge of the
6 English language the candidate possesses is included.

7 64. (2) The Examinations of the Educational
8 Council for Foreign Medical Graduates. The Educational
9 Council for Foreign Medical Graduates (usually referred
10 to as E.C.F.M.G. (see brochure appended)), is spon-
11 sored by the American Hospital Association, the
12 Association of American Medical Colleges and the
13 Federation of State Medical Boards of the United States.
14 These bodies found it desirable for the foreign medical
15 graduate to be certified before coming to the United
16 States to be admitted to the responsible position of
17 interne or resident providing patient care. It was
18 found essential that the United States hospitals secure
19 evidence that the foreign trained physician is a
20 graduate of a recognized school of medicine and has
21 met the minimum requirements, approximately equivalent
22 to those required of United States medical graduates.

23 65. The E.C.F.M.G. sets The American
24 Medical Qualification Examinations for these foreign
25 medical graduates. They are held twice a year in various
26 Latin American, European, African and Far Eastern
27 centers.

28 66. The Minimum Requirements as outlined
29 by E.C.F.M.G. are:

30 67. (1) That the foreign medical graduate



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pathology, bacteriology and pharmacology. Usually

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Medical Qualification Examinations for these foreign

medical graduates. They are held twice a year in various

Latin American, European, African and Far Eastern

66. The Minimum Requirements as outlined

67. (1) That the foreign medical graduate



1 has completed at least 18 years of formal education,
2 including at least 4 years in a bona fide medical
3 college.

4 68. (b) That the candidate's command of
5 written and spoken English is such to enable him to
6 take a good medical history from a patient who speaks
7 only English and to make a suitable written record
8 of that history.

9 69. (c) That the candidate's knowledge of
10 medicine and his ability to reason, using his medical
11 knowledge, are sufficient to permit him to serve as an
12 interne in a hospital with credit to himself and
13 safety to the patient.

14 70. The examinations are chiefly objective,
15 multiple choice question type, are comprehensive and
16 largely clinical.

17 71. Graduates of medical schools in Canada
18 and Puerto Rico are exempt from these examinations when
19 going to the United States, since medical schools in
20 these countries are under continuous inspection and
21 approval by the Council on Medical Education and
22 Hospitals of the American Medical Association and the
23 Associations of American Medical Colleges.

24 72. (c) Certificate of Completion of a
25 Satisfactory Rotating Internship in a Hospital
26 Approved by the Licensing Authority. Practically all
27 licensing authorities in Canada require the foreign
28 medical graduates to complete a twelve months' satis-
29 factory rotating internship in an approved hospital
30 in Canada or the United States, before admitting him

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including at least 4 years in a bona fide medical

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written and spoken English is such to enable him to
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medical graduates to complete a twelve months' satis-
factory rotating internship in a hospital in Canada or the United States, before admitting him

1 to the licensure examinations.

2 73. While at the present time there may be
3 divergence of views as to the methods used in screen-
4 ing foreign medical graduates, yet there is no
5 difference of opinion for the very real need to
6 ensure that all foreign medical graduates meet at least
7 minimum medical education requirements, have a good
8 command of the English language and complete a satis-
9 factory internship in an approved hospital. These
10 are the guides used in Nova Scotia before admitting
11 a foreign medical graduate to licensing examinations.

12 74. These conclusions are the results of
13 experience gained in the past few years. It might
14 be well to emphasize that in Nova Scotia there is no
15 inclination nor desire to make the entrance of the
16 foreign medical graduate to medical practice difficult,
17 but rather the protection of the public is the para-
18 mount factor.

19 75. It should also be emphasized that the
20 Provincial Medical Board is interested in maintaining
21 high standards of medical education and medical practice
22 in Nova Scotia, and should make full use of legislation
23 and regulations available to it, to ensure that poorly
24 or inadequately trained foreign medical graduates are
25 not registered to look after the health needs of Nova
26 Scotians.

27 76. We would like to thank the Commission
28 for the opportunity of presenting this submission and
29 would like to assure you of our complete cooperation in
30 providing any further information which you may require.



73. While at the present time there may be divergence of views as to the methods used in screening foreign medical graduates, yet there is no difference of opinion as to the fact that all foreign medical graduates must at least ensure that all foreign medical graduates, have a good minimum medical education-requirements, have a good command of the English language and complete a satisfactory internship in an approved hospital. These are the guides used in Nova Scotia before admitting a foreign medical graduate to the medical profession. 74. These conclusions are the results of experience gained in the past few years. It will be seen that the main factor in the selection nor desire to make the entrance of the foreign medical graduate to medical practice difficult, but rather the protection of the public is the paramount factor.

75. It should also be emphasized that the Provincial Medical Board is interested in maintaining high standards of medical education and medical practice in Nova Scotia, and should make full use of legislation and regulations available to it, to ensure that poorly or inadequately trained foreign medical graduates are not registered to look after the health needs of Nova Scotia.

76. We would like to thank the Commission for the opportunity of presenting this submission and would like to assure you of our complete cooperation in providing any further information which you may require.



TABLE I

Number of Physicians
Registered and Residing in Nova Scotia

also showing

School of Graduation

June 30, 1961

Physicians Registered	NO.	School of Graduation		
		Dalhousie	Other Canadian	Other
Active General Practice	385	290	33	62
Active Specialty Practice	212	137	26	49
Sub-Total	597	427	59	111
Taking Graduate Training	56	39	3	14
Administrative et al	66	39	7	20
Females not in Practice	18	5	1	12
Military Service	37	4	15	18
Retired	33	24	3	6
Moved From Nova Scotia	2	2	0	0
TOTAL	809	540	88	181

TABLE II

Number of physicians
in
Specialty Practice in Nova Scotia, June 30, 1961

Also Showing School of Graduation

Specialty	No.	School of Graduation		
		Dalhousie	Other Canadian	Other
Internal Medicine	24	20	3	1
Dermatology	3	1	0	2
Psychiatry	22	12	1	9
E.E.N.T.	29	20	4	5
Anaesthesia	16	10	2	4
Obstetrics and Gynaecology	11	8	1	2
Pathology and Bacteriology	13	1	1	11
Diagnostic Radiology	21	10	4	7
Radiotherapy	3	0	1	2
Pediatrics	12	9	1	2
Neurosurgery	2	1	1	0
Physical Medicine	2	2	0	0
General Surgery	43	35	6	2
Orthopedic Surgery	6	3	1	2
Urology	5	5	0	0
TOTAL	212	137	26	49

* This does not include physicians doing general practice, with a major interest in some specialty - only certified (or better) specialists.

Also Showing School of Graduation

School of Education



TABLE III

Number of New Registrants in
Medical Register - Nova Scotia
1951 and 1961

New Registrants	1951	1961
Dalhousie Graduates	19	46
Other Canadian Graduates	12	6
General Medical Council Registrants	10	34
Others	6	17
TOTAL	47	103

* Includes all registrants, whether residing in
Nova Scotia or not.

Number of New Registrants in
Medical Register - Nova Scotia
1951 and 1952

New Registrants	1951	1952
Diplomate Graduates	12	46
Other Canadian Graduates	12	0
General Medical Council Registrants	10	34

* Includes all registrants, whether residing in
Nova Scotia or not.



TABLE IV

Comparison

Number of Physicians on
Resident List of Medical Register

Nova Scotia - 1951 and 1961

Registrants	1951	1961
Dalhousie Graduates	447	540
Other Canadian Graduates	97	88
General Medical Council Registrants	50	144
Others	14	37
TOTAL	608	809

TABLE I

Number of Physicians on
Resident List of Medical Register
Nova Scotia - 1951 and 1961

1961	1951	Registrants
540	447	Dalhousie Graduates
88	97	Other Canadian Graduates
144	50	General Medical Council Registrants
37	14	Others
809	608	TOTAL



ADDENDUM

Attached are the following -

- (1) The Medical Act of Nova Scotia.
- (2) Brochure issued by the Educational Council
for Foreign Medical Students.

- - - - -



The Medical Act of Nova Scotia.

Brochure issued by the Educational

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1 THE CHAIRMAN: Are there any questions
2 arising out of this?

3 MR. HALL: Mr. Chairman, there was just this
4 one question that occurred. Reference in the brief is
5 made to the difficulty of assessing graduates of foreign
6 universities. Could there not be a rating of foreign
7 medical schools established, which would give quick and
8 handy reference of the qualifications of a proposed appli-
9 cant?

10 DR. MACDONALD: I am afraid I am not capable
11 of answering that. There is no body at the present time.
12 I think prior to the Second World War the American College
13 of Physicians and Surgeons, in association I think with
14 the American Medical Colleges, used to inspect some of the
15 foreign medical schools, but since the war they have not
16 been able to do that.

17 THE CHAIRMAN: Very well, your brief, Dr.
18 MacNeil and Dr. Macdonald is of course self-evident, I
19 mean it deals with the statutory and other provisions
20 under which the practice of medicine is carried on in
21 Nova Scotia, and this is a document, the information in
22 which we will need and are very pleased to have.

23 Thank you very much.

24 We have Dr. Kelly, who has a document to
25 file.

26 SUBMISSION OF THE CANADIAN MEDICAL ASSOCIATION

27 Appearance: Dr. A.D. Kelly

28 DR. KELLY: I will attempt to be almost as
29 brief as my friend Dr. Macdonald. My purpose is simply
30 to present you with an exhibit which constitutes a study



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DR. KELLY: I will attempt to be almost as

brief as my friend Dr. Macdonald. My purpose is simply

to present you with an exhibit which constitutes a study



1 conducted by the Canadian Medical Association of future
2 requirements for physicians in Canada. I think, Mr.
3 Chairman, it is quite evident that the persons who have
4 testified before this Commission today find that personnel
5 problems loom large in their minds, and we have undertaken
6 to assemble what data is available, to incorporate it in
7 terms of the future requirements for doctors in Canada up
8 to the year 1980. We hope that you will find this study
9 a useful one, and I think, if I may just remark, that the
10 lessons to be learned are these: that if we are to continue
11 to supply doctors in adequate numbers to provide the
12 service which our people require, that we will not be able
13 to depend as we have in the past few years on immigration
14 to this country, although that will continue to be a fac-
15 tor, but that the 12 medical schools which are now produ-
16 cing doctors should be encouraged to increase their output
17 as speedily as possible, and I think certain other univer-
18 sities, which are considering whether or not they should
19 educate doctors, should be encouraged to do so.

20 THE CHAIRMAN: Thank you very much, Dr.
21 Kelly. This is the document of which you spoke at the
22 September 27th meeting that would be forthcoming?

23 DR. KELLY: Yes sir.

24 THE CHAIRMAN: It will be entered as
25 Exhibit No. 6.

26
27 --- EXHIBIT NO. 6: Submission of the Canadian Medical
28 Association.
29
30



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lessons to be learned are these: that if we are to continue

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educate doctors, should be encouraged to do so.

THE CHAIRMAN: Thank you very much, Dr.

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September 27th meeting that would be forthcoming?

DR. KELLY: Yes sir.

THE CHAIRMAN: It will be a very interesting document.

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SUBMISSION

OF

THE CANADIAN MEDICAL ASSOCIATION

Appearance: Dr. A. D. Kelly.

THE CANADIAN MEDICAL ASSOCIATION

FUTURE REQUIREMENTS FOR PHYSICIANS IN CANADA

In our preliminary submission to the
Royal Commission on Health Services we stated:

"A rough measure of adequacy of medical services is the physician-population ratio. During the period 1900-1950 the national ratio in Canada has been, with remarkable constancy, of the order of 1:980. We estimate that the current ratio is 1:888 (Ratio for September 1, 1960.), a more favourable figure than we have ever enjoyed, and one which compares favourably with that of the more advanced countries of the Western world. It will be appreciated that ratios of the type mentioned here represent gross figures of medically qualified persons and that not all of the doctors are engaged in the care of patients. We are conscious, moreover, that medical immigration during the past ten years has contributed materially to Canada's medical manpower and that without this advantage, which may be temporary, the physician-population ratio would have deteriorated. In other words,

Appearance: Dr. A. D. Kelly.

THE CANADIAN MEDICAL ASSOCIATION
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1 we are not producing enough doctors in Canada to
2 keep pace with our rapidly expanding population.
3 The supply is just adequate under current conditions
4 of practice and almost certainly would be inade-
5 quate to staff new and demanding areas of health
6 services."

7 In this present document we have
8 collated existing information in as specific a form as is
9 possible. Unfortunately, much of the data is not precise
10 as it evelves from informed estimates and somewhat inexact
11 statistics. We have used this information, with these
12 acknowledged limitations, to examine current trends, to
13 project requirements for medical doctors in Canada, to
14 examine our sources of supply and to assess the ability
15 of our Canadian medical schools to produce the number of
16 medical graduates which will be required in the future.

17
18 PART 1

19 THE NUMBER OF PHYSICIANS
20 IN CANADA

21
22 The Physician-Population Ratio

23 One method of assessing the require-
24 ments for physicians is to examine the physician-population
25 ratio. Table I shows the historical record of the number
26 of doctors in Canada, from the beginning of this century
27 until 1951, and the ratio which this bears to the total
28 population of the country.
29
30



TABLE I

Physician-Population Ratios in Canada
Ten Year Periods, 1901 to 1951

<u>Year</u>	<u>Estimated No. of Doctors</u>	<u>Population</u>	<u>Physician-Population Ratio</u>
1901	5,475	5,371,000	1: 981
1911	7,411	7,207,000	1: 972
1921	8,706	8,788,000	1:1009
1931	10,020	10,377,000	1:1036
1941	11,873*	11,507,000	1: 969
1951	14,163	14,009,000	1: 989

Source: Department of National Health and Welfare
Survey of Physicians - 1954

* The 1941 figure includes 1,150 armed forces' doctors because of wartime conditions but the other figures exclude doctors in the armed forces since this data was not available up to 1931 and the number of doctors serving in Canada in peacetime is nominal.

While Table I shows that the national physician-population ratio has not changed appreciably during the first half of the century, Table II, which deals with this subject in detail for the last ten years, shows that the national physician-population ratio has improved by over 100 persons per physician in this relatively short period. An analysis of these figures on a provincial basis is given in Appendix A.

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physician-population ratio has not changed appreciably during the first half of the century, Table II, which deals with this subject in detail for the last ten years, shows that the national physician-population ratio has improved by over 100 persons per physician in this relatively short period. An analysis of these figures on a provincial basis is given in Appendix A.



TABLE II

Estimated Physician-Population Ratios

Canada, 1951 to 1960

Year	Estimated No of Doctors(1) (Dec. 31)	Estimated Population Corresponding Year and Month (2)	Physician- Population Ratio
1951(June)	14,163	14,009,000	1:989
1952	15,135	14,649,000	1:968
1953	15,829	15,195,000	1:960
1954	16,431	15,698,000	1:955
1955	17,221	16,081,000	1:934
1956	17,871	16,589,000	1:928
1957	18,523	17,048,000	1:920
1958	19,096	17,284,000	1:905
1959	19,800	17,678,000	1:893
1960	20,517	18,041,000	1:879

Sources: (1) Canadian Medical Association questionnaire to Registrars of Provincial Licensing Authorities, except for 1951 which is based on census data.

(2) Dominion Bureau of Statistics.

This improvement from 989 persons per physician in 1951 to 879 persons per physician in 1960 is a change of more than 10 per cent in the relative supply of doctors and a rate of improvement of more than one per cent per annum. The assimilation of this relatively more plentiful supply indicates a readiness on the part of the public to use the services of a greater number of doctors. We have, however, experienced a substantial



TABLE 1
Physician-Population Ratio
1951 to 1960

Year	of Doctors (1) (Dec. 31)	Corresponding Year and Month (2)	Population Ratio
1951 (June)	14,163	14,009,000	1:989
1952	15,135	14,649,000	1:968
1953	16,125	15,289,000	1:952
1954	16,431	15,668,000	1:955
1955	17,221	16,081,000	1:934
1956	17,871	16,589,000	1:928
1957	18,523	17,048,000	1:920
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of doctors. We have, however, experienced a substantial



inflow of immigrant physicians during this period and this improvement has resulted to a great extent, if not entirely, from this source of supply.

Whether or not this improvement in the physician-population ratio need continue unabated is open to question. Some further improvement would seem necessary if during the next 20 years we experience the expected increase in the proportion of persons in the older age groups. These persons require a greater number of services than those in the younger age groups. We have also found that insured persons seek more services than non-insured persons. The logical and expected expansion of the proportion of the population covered by private insurance suggests to us an increased demand for the services of doctors.

We have, therefore, prepared two sets of statistics for future requirements - one assuming that the supply of doctors and the demand for services will remain constant at the December 1960 level of 1:879, and the other assuming a continual improvement in this ratio, although at the more conservative rate of one-half of one per cent per annum. This latter assumption produced the following physician-population ratios at 1 year intervals up to 1980.

<u>Year</u>	<u>Ratio</u>	<u>Year</u>	<u>Ratio</u>	<u>Year</u>	<u>Ratio</u>
1960	1:879	1964	1:862	1968	1:845
1961	1:875	1965	1:857	1969	1:840
1962	1:870	1966	1:853	1970	1:836
1963	1:866	1967	1:849	1971	1:832

Whether or not this improvement in the supply of services will be maintained in the future is open to question. Some further improvement would seem necessary if during the next 50 years we experience the expected increase in the proportion of persons in the population of the proportion of the population covered by private insurance suggests to us an increased demand for the services of doctors.

We have, therefore, prepared two sets of statistics for future requirements - one assuming that the supply of doctors and the demand for services will remain constant at the December 1960 level of 1:879, and the other assuming a continual improvement in this ratio, although at the more conservative rate of one-half of one per cent per annum. This latter assumption produced the following physician-population ratios at 1 year intervals up to 1980.

Year	Physician	Population	Ratio
1960	1:879	1960	1:879
1961	1:875	1961	1:875
1962	1:871	1962	1:871
1963	1:867	1963	1:867
1964	1:863	1964	1:863
1965	1:859	1965	1:859
1966	1:855	1966	1:855
1967	1:851	1967	1:851
1968	1:847	1968	1:847
1969	1:843	1969	1:843
1970	1:839	1970	1:839
1971	1:835	1971	1:835
1972	1:831	1972	1:831
1973	1:827	1973	1:827
1974	1:823	1974	1:823
1975	1:819	1975	1:819
1976	1:815	1976	1:815
1977	1:811	1977	1:811
1978	1:807	1978	1:807
1979	1:803	1979	1:803
1980	1:799	1980	1:799



1972	1:828	1975	1:815	1978	1:803
1973	1:824	1976	1:811	1979	1:799
1974	1:819	1977	1:807	1980	1:795

From the improving ratios quoted above and the constant ratio of 1:879, it is possible to produce two projections of total doctor requirements up to 1980, based on the population projections calculated by the Royal Commission on Canada's Economic Prospects. No comment on distribution is implied in these projections of doctor requirements although we know that some unevenness exists in the physician-population ratio in regional and rural-urban settings.

Population Projections.

The Royal Commission on Canada's Economic Prospects estimated four possible levels of population in Canada for 1960, 1965, 1970, 1975 and 1980. These projections, depended, among other things on the level of net immigration. The Commission's highest population projections were based on a net immigration rate of 100,000 per annum. Other rates assumed were 75,000, 50,000 and zero.

The official population in 1960 exceeded the Commission's highest projection by 164,000 persons, being 17,814,000 in June instead of 17,650,000. If this trend continues, the Commission's highest projections up to 1980 may well prove to be a legitimate basis for the projection of doctor requirements. If, however, there is a continuation of the current downward trend in

1978	1:803	1975	1:815	1972	1:828
1979	1:799	1976	1:811	1973	1:824
1980	1:795	1977	1:807	1974	1:819

From the improving ratios quoted above and the constant ratio of 1:819, it is possible to produce two projections of total doctor requirements up to 1980, based on the population projections calculated by the Royal Commission on Canada's Economic Prospects. No comment on distribution is implied in these projections of exists in the physician-population ratio in regional and

Population Projections

The Royal Commission on Canada's Economic Prospects estimated four possible levels of population in Canada for 1960, 1965, 1970, 1975 and 1980. level of net immigration. The Commission's highest population projections were based on a net immigration rate of 100,000 per annum. Other rates assumed were 75,000, 50,000 and zero.

The official population in 1960 exceeded the Commission's highest projection by 104,000 persons, being 14,814,000 in June instead of 14,650,000. If this trend continues, the Commission's highest projections up to 1980 may well prove to be a legitimate basis for the projection of doctor requirements. It, however, there is a continuation of the current downward trend in



net immigration, the Commission's projections based on a net immigration of 75,000 per annum may be applicable. We consider it reasonable, therefore, to use the Commission's population projections based on net immigration levels of 75,000 and 100,000, for the purpose of showing doctor requirements. These two levels of population projection are shown in Table III.

TABLE III

Population Projection - Royal Commission
on Canada's Economic Prospects

Year	Projected Population For Net Immigration Level of	
	75,000	100,000
1965	19,520,000	19,820,000
1970	21,640,000	22,130,000
1975	23,990,000	24,660,000
1980	26,650,000	27,530,000

Source: Report of the Royal Commission on Canada's Economic Prospects.

Projected Doctor Requirements
Based on the Two Projected Levels of Population
And Constant and Improving Physician-Population
Ratios.

By dividing the population shown above (and the intervening interpolations) by the physician-population ratios previously determined, we are able to calculate the approximate total annual requirements for doctors up to 1980. These are shown in Table IV at selected two and three year intervals.

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Population Projection - Royal Commission

Year	Projected Population For Net Immigration Level of 75,000	Projected Population For Net Immigration Level of 100,000
1970	21,540,000	22,130,000
1975	23,990,000	24,560,000
1980	26,650,000	27,330,000

Source: Report of the Royal Commission on Canada's Economic Prospects.

Projected Doctor Requirements

Based on the Two Projected Levels of Population and Constant and Improving Physician-Population Ratios.

By dividing the population shown

above (and the intervening interpolations) by the physician-population ratios previously determined, we are able to calculate the approximate total annual requirements for doctors up to 1980. These are shown in Table IV at selected two and three year intervals.

TABLE IV

Projected Doctor Requirements

Year	Constant Ratio 1:879		Improving Ratios 1:879 to 1:795	
	No. of Doctors for min. popul'n	No. of Doctors for max. popul'n	No. of Doctors for min. popul'n	No. of Doctors for max. popul'n
1962	21,040	21,180	21,260	21,390
1965	22,210	22,550	22,770	23,120
1967	23,110	23,660	23,940	24,400
1970	24,620	25,180	25,880	26,470
1972	25,660	26,300	27,250	27,930
1975	27,290	28,060	29,420	30,250
1977	28,460	29,310	30,990	31,920
1980	30,320	31,320	33,520	34,620

This table indicates various projected increases in requirements for medical manpower in Canada, ranging by 1980, from a minimum increase of about 48 per cent to a maximum increase of about 69 per cent over 1960 levels. These figures both past and future, are gross numbers, including registered doctors who are engaged in fields other than the treatment of patients. They include doctors working in administrative capacities, those doing research, those in industry and those in postgraduate training, as well as those over the age of 65. In our projections for the next two decades we have assumed that similar allowances must be made for doctors working in similar capacities. In so doing, we anticipate that the proportion of physicians so engaged will not change appreciably during the period.

TABLE 17

Projected Requirements

Year	1980-1985		1985-1990		Improving	
	No. of Doctors for Doctors for	No. of Doctors for Doctors for	No. of Doctors for Doctors for	No. of Doctors for Doctors for	No. of Doctors for Doctors for	No. of Doctors for Doctors for
1985	21,040	21,180	21,260	21,390		
1986	22,210	22,250	22,770	23,150		
1987	23,110	23,660	23,940	24,400		
1988	24,220	24,770	25,250	25,730		
1989	25,660	26,300	27,250	27,930		
1990	27,290	28,060	29,420	30,250		
1991	28,460	29,310	30,390	31,250		
1992	30,320	31,320	32,520	34,020		

This table indicates various projected

increases in requirements for medical manpower in Canada, ranging by 1980, from a minimum increase of about 48 per cent to a maximum increase of about 99 per cent over 1960 levels. These figures both past and future, are gross numbers, including registered doctors who are engaged in fields other than the treatment of patients. They include doctors working in administrative capacities, those doing research, those in industry and those in postgraduate training, as well as those over the age of 65. In our projections for the next two decades we have assumed that similar allowances must be made for doctors working in similar capacities. In so doing, we anticipate that the proportion of physicians so engaged will not change appreciably during the period.



PART II

THE MEANS FOR SUPPLYING CANADIAN PHYSICIAN REQUIREMENTS

The foregoing section has concerned itself with establishing the existing ratio of physicians to population and the projected future requirements for doctors. This section will concern itself with a consideration of the supply of doctors needed to meet these future requirements.

There are two sources of supply of Canadian doctors, the Canadian Medical Schools and foreign graduates who emigrate to Canada. The record of output of Canadian Medical Schools is known-although even the total supply from this source is obscured by the number of Canadian graduates who leave the country to practise elsewhere or who return at an undetermined date after prolonged absence. The record of supply from foreign sources began only in 1953, when the Department of Citizenship and Immigration started to separate the occupations of all immigrants in the different professions. The number of immigrant physicians which we have received since that date is shown in Table V.

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since that date is shown in Table V.

TABLE V

Physician and Surgeon Immigrants into Canada
1953 to 1960

National Origin	1953	1954	1955	1956	1957	1958	1959	1960	Total
Austrian	13	6	7	8	5	4	-	2	45
British	195	160	195	214	311	202	182	162	1,621
Chinese	33	1	15	5	-	5	29	20	78
East Indian	1	1	-	3	11	10	19	25	70
French	9	1	1	6	8	5	5	1	36
German	40	23	20	31	13	15	9	11	167
Hungarian	6	2	1	31	117	9	2	8	176
Italian	6	1	3	14	10	12	15	13	74
Jewish	16	13	9	11	49	18	23	9	148
Nether-lander	20	27	11	6	11	16	16	10	117
Polish	14	18	7	5	6	8	9	4	71
Spanish	3	2	2	8	9	10	22	32	88
U.S.A.	55	39	33	29	46	52	66	84	404
Others	21	17	29	44	34	28	42	60	275
Totals	402	311	333	415	635	394	439	441	3,370

Source: Department of Citizenship and Immigration.

The foregoing table shows that during the period 1953 to 1960 Canada received 3,370 immigrant doctors. In the same period Canadian medical schools graduated 6,874 new doctors. It is difficult to say how long, on the average, it takes for these two varied groups of doctors to obtain full registration. Some British doctors obtain immediate registration in certain provinces,



TABLE 1

Immigrants from the United Kingdom, 1953 to 1960

Origin	1953	1954	1955	1956	1957	1958	1959	1960	Total
Austrian	13	6	7	8	5	4	-	2	44
British	195	160	195	214	311	202	182	162	1,624
Chinese	33	1	15	5	-	5	29	20	78
East Indian	1	1	-	3	11	10	19	25	70
French	9	1	1	6	8	5	5	1	36
German	6	1	3	14	10	12	15	13	74
Italian	20	27	11	6	11	16	16	10	121
Nether-	14	12	7	5	6	8	9	-	71
Polish	3	2	2	8	2	10	22	-	47
Spanish	55	39	37	29	40	52	62	-	354
U.S.A.	21	17	29	44	34	28	42	-	235
Others	402	311	333	415	635	394	439	-	2,938

Source: Department of Citizenship and Immigration

The foregoing table shows that during the period 1953 to 1960 Canada received 3,370 immigrants from the United Kingdom. In the same period Canadian medical schools graduated 6,874 new doctors. It is difficult to say how long, on the average, it takes for these two varied groups of doctors to obtain full registration. Some British doctors obtain immediate registration in certain provinces.



1 while some other immigrants may take several years. Some
2 Canadian graduates also, may extend their intern training
3 for more than one year. If we say, however, that between
4 these two extremes, we are going to assume an average
5 period of delay of one year before each potential doctor
6 enters the fully registered lists, we are probably coming
7 fairly close to a reasonable approximation. On this
8 basis, we find that domestic and immigrant sources could
9 have contributed 8,940 new registered doctors to the
10 Canadian scene between 1953 and 1960. In actual fact,
11 however, the supply of Canadian doctors rose by only
12 5,382 during this period. A comparison of these two
13 figures, an increase of only 5,382 actual doctors out of
14 a potential total of 8,940, highlights a major problem
15 in projecting the number of new doctors that must be
16 injected into the stream each year in order to reach a
17 given level of supply. Obviously, there must be a con-
18 siderable degree of loss or attrition in the medical
19 force each year. This attrition arises both from the
20 older doctors who die or retire, and from the new graduates
21 who may go to some other country either to continue their
22 studies or to engage in practice. Some immigrants may
23 also pass on to other countries after staying in Canada
24 for only a limited time. The degree of loss from each of
25 these causes cannot be isolated, but must be treated as
26 part of a composite loss from all sources. The discovery
27 and application of the rate of this loss is of critical
28 importance in being able to project the future rates at
29 which Canadian medical schools must graduate new doctors
30 and/or the rate at which we must receive new immigrant

for more than one year. If we say, however, that between these two extremes, we are going to assume an average period of delay of one year before each potential doctor enters the fully registered lists, we are probably coming fairly close to a reasonable approximation. On this basis, we find that domestic and immigrant sources could have contributed 8,940 new registered doctors to the Canadian scene between 1953 and 1960. In actual fact, however, the supply of Canadian doctors rose by only 5,382 during this period. A comparison of these two figures, an increase of only 5,382 actual doctors out of a potential total of 8,940, highlights a major problem in projecting the number of new doctors that must be injected into the stream each year in order to reach a given level of supply. Obviously, there must be a considerable degree of loss or attrition in the medical force each year. This attrition arises both from the older doctors who die or retire, and from the new graduates who may go to some other country either to continue their studies or to engage in practice. Some immigrants may also pass on to other countries after staying in Canada for only a limited time. The degree of loss from each of these causes cannot be isolated, but must be treated as part of a composite loss from all sources. The discovery and application of the rate of this loss is of critical importance in being able to project the future rates at which Canadian medical schools must graduate new doctors and/or the rate at which we must receive new immigrants.



doctors.

The calculation of this rate of attrition for the past seven years, the only period for which the input of both new immigrant doctors and new Canadian graduates is known, is shown in Table VI. Starting at December 31st, 1953, (equivalent to January 1st, 1954) with an actual supply of 15,829 doctors, we have added the number of Canadian graduates in 1953 and the number of immigrant physicians who entered the country during 1953, (both of which groups would then have had the opportunity to qualify for full registration) which gives a theoretical total of 17,056 doctors at the end of 1954. In actual fact, however, we had only 16,431 doctors registered on December 31st, 1954, so that there was a loss or attrition of 625 doctors out of an average number for the year of 16,130. This is equivalent to a rate of attrition of 3.87 per cent. Repeating this process for the period as a whole up to December 31st, 1960, we are able to determine an average attrition for the seven years. This calculation is shown in the following table:

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TABLE VI

Average Attrition Amongst Canadian Doctors
For the period 1954 to 1960

Year	No. of Doctors at start of year	Canadian Graduates	Immigrant Doctors	Theoretical Total	Actual Total at end of yr.	Loss in Nos.	Average No. of Doctors in yr.	Per Cent Attrition
1954	15,829	825	402	17,056	16,431	625	16,130	3.87
1955	16,431	896	311	17,638	17,221	417	16,826	2.48
1956	17,221	894	333	18,448	17,871	577	17,546	3.29
1957	17,871	816	415	19,102	18,523	579	18,197	3.18
1958	18,523	893	635	20,051	19,096	955	18,809	5.08
1959	19,096	828	394	20,318	19,100	518	19,448	2.66
1960	19,800	859	439	21,098	20,517	581	20,158	2.88
Average Attrition:								3.35

This table indicates that the rate of attrition since 1954 has averaged 3.35 per cent. Although it would be desirable to determine the rate of attrition from the actual experience of the individual members of the medical profession during these years, this data is not available. We do know, however, that the 3.35 per cent rate will have been influenced by such factors as the Hungarian uprising of 1956-57, which caused an abnormally high influx of Hungarian doctors into Canada whose experience while here probably includes an abnormally high rate of attrition. This is one of the factors that might indicate that the 3.35 per cent rate may be somewhat high especially when we note the downward trend below three per cent in the last two years.

Looking to the future, however, the development of pension plans specifically designed for

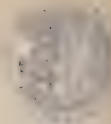


TABLE 1 ATTENTION DEFICIT DISORDER (ADD) - PREVALENCE

Year	No. of Cases	Grand Total	Actual Total	Average Per Cent
1954	15,829	402	17,056	3.8
1955	17,221	411	18,102	3.1
1956	17,871	415	18,923	3.1
1957	18,523	417	19,102	3.1
1958	19,096	424	20,318	3.6
1959	19,800	427	21,000	3.6

This table indicates that the rate

of attention since 1954 has averaged 3.35 per cent. Although it would be desirable to determine the rate of attrition from the actual experience of the individual members of the medical profession during these years, this data is not available. We do know, however, that the 3.35 per cent rate will have been influenced by such factors as the Hungarian uprising of 1956-57, which caused an abnormally high influx of Hungarian doctors. This is one of the factors that might indicate that the 3.35 per cent rate may be somewhat high especially when we note the downward trend below three per cent in the last two years. Looking to the future, however, the development of pension plans specifically designed for

doctors may create an increasing trend toward earlier retirement, with consequently greater attrition from this factor. It may not be wise, therefore, to estimate a future average rate of attrition below 3 per cent, nor as high as 3.35 per cent, as indicated above. For these reasons, we have decided to assume a flat rate exactly at the 3 per cent level for future calculations of attrition.

The Projected Annual Input of Doctors
From Canadian and Immigrant Sources, Required
To Provide the Projected Levels of Medical Manpower,
in Canada, Up to 1980

On the basis of this assumption, it is now possible to project the total number of new doctors that it will be necessary to inject into the mainstream of the Canadian physician supply each year, to make that stream grow to the projected size required. It is necessary to emphasize that the annual requirements which will be indicated are those which will be required from a combination of domestic and immigration sources, and not from Canadian medical schools alone.

In order to produce the number of new doctors which must be introduced into the mainstream of doctor supply each year, it is necessary to consider three factors:

1. Those new doctors who will be required annually purely to keep pace with the projected increase in population - at a ratio of one doctor for each 879 persons.

retirement, with consequently greater attrition from this factor. It may not be wise, therefore, to estimate a future average rate of attrition below 3 per cent, nor as high as 3.35 per cent, as indicated above. For these reasons, we have decided to assume a 3.15 rate exactly at the 3 per cent level for future calculations of attrition.

The Projected Annual Input of Doctors
From Canadian and Immigrant Sources, Required
To Provide the Projected Levels of Medical Manpower,
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On the basis of this assumption, it is now possible to project the total number of new doctors that it will be necessary to inject into the mainstream of the Canadian physician supply each year, to make that stream grow to the projected size required. It is necessary to emphasize that the annual requirements which will be indicated are those which will be required from a combination of domestic and immigration sources, and not from Canadian medical schools alone.

In order to produce the number of new doctors which must be introduced into the mainstream of doctor supply each year, it is necessary to consider three factors:

1. Those new doctors who will be required annually purely to keep pace with the projected increase in population - at a ratio of one doctor for



2. Those additional new doctors who will be required annually in order to improve the physician-population ratio by .5 per cent annually, reaching an apparent level of 1:795 in 1980.
3. Those new doctors required annually to replace other doctors lost through the various causes of attrition, at the rate of 3 per cent of the total each year.

It will be realized that these three factors must be considered in the light of both our higher population projection and the lower one. Again, we may choose to consider only the number of doctors which must be added to the stream at the constant 1:879 physician-population ratio or at the improving (up to 1:795) ratio. Both these latter points will affect the number of doctors needed as replacements - since the greater the total number of doctors required, the greater will be the attrition at the rate of 3 per cent of the total. In order to illustrate how these considerations may be applied in practice, we have outlined a table for each of the four main sets of circumstances which need to be considered, i.e., for the higher population projection - the upper (improving ratio) and lower (constant ratio) calculations of annual new doctor requirements; and for the lower population projections, a similar set of two calculations. These are shown below in Table VII.

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population ratio by 5 per cent annually.

quired annually in order to improve the physician-

2. Those additional new doctors who will be re-



TABLE VII

710

Projected Annual Requirements for Additional Doctors
From Both Domestic and Immigrant Sources
1965, 1970, 1975 & 1980

1. Lower Population Projection - Constant Physician-Population Ratio

Year (June)	Population	Ratio	Total Doctor Requ'ts	Additional Doctors Required For			Additional Doctors from Domestic and Immigrant sources
				Population Increase	Improving Ratio	Attrition at 3%	
1965	19,520,000	1:879	22,210	390	-	660	1050
1970	21,640,000	1:879	24,620	510	-	740	1250
1975	23,990,000	1:879	27,290	560	-	820	1380
1980	26,650,000	1:879	30,320	640	-	910	1550

2. Lower Population Projection - Improving Physician-Population Ratio

Year (June)	Population	Ratio	Total Doctor Requ'ts	Additional Doctors Required For			Additional Doctors from Domestic and Immigrant sources
				Population Increase	Improving Ratio(1)	Attrition at 3%	
1965	19,520,000	1:857	22,770	390	120	680	1190
1970	21,640,000	1:836	25,880	510	150	780	1440
1975	23,990,000	1:815	29,420	560	190	880	1630
1980	26,650,000	1:795	33,520	640	230	1,000	1870

3. Higher Population Projection - Constant Physician-Population Ratio

Year (June)	Population	Ratio	Total Doctor Requ'ts	Additional Doctors Required For			Additional Doctors from Domestic and Immigrant sources
				Population Increase	Improving Ratio	Attrition at 3%	
1965	19,820,000	1:879	22,550	460	-	670	1130
1970	22,130,000	1:879	25,180	550	-	760	1310
1975	24,660,000	1:879	28,060	600	-	840	1440
1980	27,530,000	1:879	31,320	690	-	940	1630

4. Higher Population Projection - Improving Physician-Population Ratio

Year (June)	Population	Ratio	Total Doctor Requ'ts	Additional Doctors Required For			Additional Doctors from Domestic & Immigrant sources
				Population Increase	Improving Ratio (1)	Attrition at 3%	
1965	19,820,000	1:857	23,120	460	130	690	1280
1970	22,130,000	1:836	26,470	550	160	800	1510
1975	24,660,000	1:815	30,250	600	190	910	1700
1980	27,530,000	1:795	34,620	690	240	1,040	1970

(1) The figures shown in Table VII are for 1965 over 1964; 1970 over 1969; 1975 over 1974 and 1980 over 1979, taking into account the gradual improvement in the ratios shown on Page 4.

TABLE VII

Projected Annual Requirements for Additional Doctors
From Birth Rates, 1965, 1970, 1975 & 1980

1. Lower Population Projection - Constant Physician-Population Ratio

Year (June)	Population	Ratio	Total Doctors Required	Population Increase	Ratio Improving At 3%	Additional Doctors Required For Improving Ratio	Additional Doctors From Domestic and Immigrant Sources
1965	19,520,000	1:875	22,470	370	120	680	1950
1970	21,640,000	1:836	25,480	510	120	750	1950
1975	23,920,000	1:815	29,430	560	120	820	1950
1980	26,620,000	1:795	33,320	640	120	910	1950

2. Lower Population Projection - Improving Physician-Population Ratio

Year (June)	Population	Ratio	Total Doctors Required	Population Increase	Ratio Improving At 3%	Additional Doctors Required For Improving Ratio	Additional Doctors From Domestic and Immigrant Sources
1965	19,520,000	1:875	22,470	370	120	680	1950
1970	21,640,000	1:836	25,480	510	120	750	1950
1975	23,920,000	1:815	29,430	560	120	820	1950
1980	26,620,000	1:795	33,320	640	120	910	1950

3. Higher Population Projection - Constant Physician-Population Ratio

Year (June)	Population	Ratio	Total Doctors Required	Population Increase	Ratio Improving At 3%	Additional Doctors Required For Improving Ratio	Additional Doctors From Domestic and Immigrant Sources
1965	19,820,000	1:879	22,560	460	-	970	1950
1970	22,120,000	1:879	25,180	530	-	960	1950
1975	24,660,000	1:879	28,060	600	-	940	1950
1980	27,520,000	1:879	31,320	690	-	940	1950

Year (June)	Population	Ratio	Total Doctors Required	Population Increase	Ratio Improving At 3%	Additional Doctors Required For Improving Ratio	Additional Doctors From Domestic and Immigrant Sources
1965	19,820,000	1:879	22,560	460	100	800	1950
1970	22,120,000	1:879	25,180	530	100	910	1950
1975	24,660,000	1:879	28,060	600	100	910	1950
1980	27,520,000	1:879	31,320	690	100	910	1950

(1) The figures shown in Table VII are for 1965 over 1964; 1970 over 1969; 1975 over 1974 and 1980 over 1975, taking into account the gradual improvement in the ratios shown on Page 6.



This table illustrates how the total annual requirements for new doctors are built up. It gives four prospective levels of new doctor requirements based on varying considerations. We must now consider these requirements in the light of the present capacity of our medical schools to graduate new doctors. In order to simplify this presentation however, and to provide definite objectives to work toward, we have decided to take the median point between our highest and lowest projected requirements and to discuss only these requirements in terms of our present medical school capacity. The median requirements, year by year up to 1975-75 and 1979-80 are as follows:

<u>Year</u>	<u>Median Doctor Requirements</u>
1960-61	1100
1961-62	1115
1962-63	1130
1963-64	1145
1964-65	1165
1965-66	1230
1966-67	1265
1967-68	1300
1968-69	1335
1969-70	1370
1970-71	1400
1971-72	1435
1972-73	1480
1973-74	1505
1974-75	1540
1979-80	1760



This table illustrates how the total annual requirements for new doctors are built up. It is based on varying considerations. We must now consider these requirements in the light of the present capacity of our medical schools to graduate new doctors. In order to simplify this presentation however, and to provide a basis of comparison, we have assumed that the requirements in terms of our present medical school capacity. The median requirements, year by year up to 1975-76 and 1976-77 are as follows:

<u>Year</u>	<u>Median Doctor Requirements</u>
1960-61	1100
1961-62	1115
1962-63	1130
1963-64	1145
1964-65	1160
1965-66	1175
1966-67	1190
1967-68	1205
1968-69	1220
1969-70	1235
1970-71	1250
1971-72	1265
1972-73	1280
1973-74	1295
1974-75	1310
1975-76	1325
1976-77	1340



These median requirements will provide a slightly improving physician-population ratio for both the lower and upper population projections. They reflect a population trend that is lower on the average in the period from 1961 to 1965 than was the case from 1956 to 1961, followed by a major upward change in direction in 1965-66 which continues to the end of the projected period. Since these requirements are somewhat in excess of current levels of medical school output, however, it will be necessary to consider to what extent we will have to rely upon immigration to fulfil our requirements. During the next four years the number of immigrants we will need will be governed by the number of students that are already in the training stream. This group of students has already predetermined the approximate number of graduates which will be produced, since, on a national average for the past five years, for every hundred first year medical students, we have received 85 graduates. On this basis we are able to project the estimated total number of graduates up to 1963-64, and by deducting these from our median requirements, to arrive at the number of immigrants we will probably require to fill our annual quota of new doctors. This is shown in Table VIII.

These median requirements will provide a slightly improving physician-population ratio for both the lower and upper population projections. They reflect a population trend that is lower on the average in the period from 1961 to 1965 than was the case from 1956 to 1961, followed by a major upward change in direction in 1965-66 which continues to the end of the projected period. Since these requirements are somewhat in excess of current levels of medical school output, however, it will be necessary to consider to what extent we will have to the next four years the number of immigrants we will need will be governed by the number of students that are already in the training stream. This group of students has already predetermined the approximate number of graduates which will be produced, since, on a national average for the past five years, for every hundred first year medical students, we have received 85 graduates. On this basis we are able to project the estimated total number of graduates up to 1963-64, and by deducting these from our median requirements, to arrive at the number of immigrants we will probably require to fill our annual quota of new doctors. This is shown in Table VIII.



TABLE VIII

The Projected Requirements for Immigrant Physicians
Up to 1963-64, On the Basis of Projected Total Require-
ments Less the Estimated Actual Number of Medical
School Graduates

Year	Total Doctor Requirements	Estimated No. of Graduates	Residual No. of Immigrants Required
1960-61	1100	825	275
1961-62	1115	840	275
1962-63	1130	805	325
1963-64	1145	820	325

This table shows that the level of immigration required in the period up to 1963-64 will reach 325 in the latter two years. During the past ten years, the immigrant inflow as shown in Table V averaged about 420 doctors per annum. In looking to the future, however, it is necessary to take a cautious view of the number of immigrants which we will receive. It may well be that the conditions which fostered past levels of physician immigration will not apply to the same degree. However, we do not consider it unreasonable to assume that we may continue to receive an average number approximating the number we will need to receive in 1963-64, namely 325 per year. By deducting this number of immigrants from our projections of total annual new doctor requirements, we are able to estimate the approximate number of new graduates that it will be necessary for our medical schools to produce up to 1969-70 and for the years beyond. We have adopted this method rather than assuming that doctor immigration will form a certain proportion of total immigration since medical immigration, on the whole, will not be influenced by the same factors

The Projected Requirements for Immigrant Physicians Up to 1963-64. On the Basis of Projected Total Residuals

Total Doctor	Estimated No.	Residual No. of
1960-61	1100	275
1961-62	1115	275
1962-63	1130	285
1963-64	1145	285

This table shows that the level of

reach 325 in the latter two years. During the past two years, the immigrant inflow as shown in Table V averaged about 420 doctors per annum. In looking to the future, however, it is necessary to take a cautious view of the number of immigrants which we will receive. It may well be that the conditions which fostered past levels of physician immigration will not apply to the same degree. However, we do not consider it unreasonable to assume that we may continue to receive an average number approximating the number we will need to receive in 1963-64, namely 325 per year. By deducting this number of immigrants from our projections of total annual new doctor requirements, we are able to estimate the approximate number of new graduates that it will be necessary for our medical schools to produce up to 1969-70 and for the years beyond. We have adopted this method rather than assuming that doctor immigration will form a certain proportion of total immigration since medical immigration on the whole, will not be influenced by the same factors

that affect the larger mass of immigrants. Our calculations on the basis of an annual inflow of 325 doctors, therefore, are shown in Table IX.

TABLE IX

Projected Requirements for Medical School Graduates up to 1974-75 and 1979-80, On the Basis of Total Requirements Less the Projected Number of Immigrants

<u>Year</u>	<u>Total Doctor Requirements</u>	<u>Projected Immigration</u>	<u>Medical School Graduates Required</u>
1964-65	1165	325	840
1965-66	1230	325	905
1966-67	1265	325	940
1967-68	1300	325	975
1968-69	1335	325	1010
1969-70	1370	325	1045
1970-71	1400	325	1075
1971-72	1435	325	1110
1972-73	1470	325	1145
1973-74	1505	325	1180
1974-75	1540	325	1215
1979-80	1760	325	1435

The peak number of graduates produced by Canadian medical schools was 896 in 1953-54. This table indicates that they will have to be able to produce a number of graduates in excess of the 900 mark by 1965-66. Whether the facilities and staff are presently equal to this task is a matter for urgent consideration, since in order to produce 905 graduates in 1965-66, an estimated first year class of about 1065 students will have to begin

that affect the larger mass of immigrants. Our calculations on the basis of an annual inflow of 325 doctors, therefore, are shown in Table IX.

TABLE IX

Projected Requirements for Medical School Graduates up to 1974-75 and 1979-80, on the Basis of Total Requirements Less the Projected Number of Immigrants

Year	Total Requirements	Projected Number of Immigrants	Projected Number of Graduates
1964-65	1165	325	840
1965-66	1230	325	905
1966-67	1265	325	940
1967-68	1300	325	975
1968-69	1335	325	1010
1969-70	1370	325	1045
1970-71	1400	325	1075
1971-72	1435	325	1110
1972-73	1470	325	1145
1973-74	1505	325	1180
1974-75	1540	325	1215
1979-80	1760	325	1435

The peak number of graduates produced by Canadian medical schools was 840 in 1964-65. This table indicates that they will have to produce a number of graduates in excess of the 400 mark by 1965-66. Whether the facilities and staff are presently equal to this task is a matter for our consideration, since in order to produce 900 graduates in 1979-80, an estimate of about 1000 students will have to be in the first year class of about 1965 students will have to be in the



their studies in the Fall of 1962 - only one year from now. This introduces the question of the required future enrolment capacity of Canadian medical schools, given the stated levels of graduation.

Enrolment Implications For Canadian Medical Colleges

The foregoing Table IX shows the apparent need for medical graduates up to 1974-75 and 1979-80. Translated into terms of first year enrolment, in the professional medical colleges, these requirements would be as follows:

TABLE X

Required First Year Enrolment in Canadian Medical Colleges

<u>Year</u>	<u>First Year Enrolment</u>
1962-63	1065
1963-64	1105
1964-65	1145
1965-66	1185
1966-67	1225
1967-68	1265
1968-69	1305
1970-71	1345
1971-72	1430
1976-77	1690

As mentioned before, this table shows that Canadian medical school first year enrolment will have to increase in the fall of 1962 to a level of 1065 students from an estimated 1961-62 first year enrolment of 1010, an increase of 55 students. The 1962-63 first

studies in the fall of 1969 - only one year from now. This introduces the question of the required future level of graduation. The stated levels of graduation.

The foregoing table shows the apparent need for medical graduates up to 1974-75 and

would be as follows:

TABLE A

Year	Estimated
1964-65	1965
1965-66	1966
1966-67	1967
1967-68	1968
1968-69	1969
1969-70	1970
1970-71	1971
1971-72	1972
1972-73	1973
1973-74	1974
1974-75	1975

As mentioned before, this table shows

that Canadian medical school first year enrolments will have to increase in the fall of 1969 to a total of 1000 students from an estimated 1961 of about 700 students.

year student quota, if it filled, would be somewhat in excess of the peak number of first year students which has been handled in the past. By 1966-67, the additional student places needed for first year entrants alone could be approximately 200 in excess of the previous maximum and by 1970-71, the excess could reach 400. The only factor which could mitigate these projections somewhat is the enrolment of a student body with a lower drop-out rate than has been experienced during recent years.

The Effect on Total Enrolment

An increase in enrolment and the provision of facilities for first year students automatically requires that facilities for second, third and fourth year students also be enlarged. The following table shows the relationship of enrolment in all four years of the course, to the total enrolment, for the years from 1948-49 onward.

TABLE XI

Medical Enrolment in Canada by Year of Course
1948-49 to 1960-61

Year	Year of Course				Total Enrolment	Graduates
	First	Second	Third	Fourth		
1948-49	887	765	842	739	3233	679
1949-50	897	798	761	822	3278	791
1950-51	960	880	844	805	3489	858
1951-52	873	891	858	836	3458	783
1952-53	918	809	865	852	3444	825
1953-54	982	901	844	916	3643	896
1954-55	968	903	881	837	3589	894
1955-56	1035	883	877	856	3651	816
1956-57	1001	934	855	865	3655	893(1)
1957-58	1012	916	928	830	3686	828
1958-59	986	911	867	904	3668	859
1959-60	946	882	863	858	3549	863
1960-61	970	842	853	843	3508	845
Totals	12435	11315	11138	10963	45851	10830
Each Yr. As % of						
Total	27.12	24.68	24.29	23.91	100.00	

(1) It is apparent that about 30 of these graduates are holdovers from the previous year.

Source: Association of Canadian Medical Colleges

year student quota, if it is filled, would be somewhat in excess of the peak number of first year students which has been handled in the past. By 1965-66, the additional student places needed for first year entrants alone could be approximately 200 in excess of the previous maximum and by 1970-71, the excess could reach 400. The only factor which could mitigate these projections somewhat is the fact that has been experienced during recent years.

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TABLE XI

Medical Enrolment in Canada by Year of Course
1945-46 to 1964-65

Year	Year of Course				Total Enrolment	Graduates
	First	Second	Third	Fourth		
1945-46	887	765	842	739	3233	679
1946-47	897	798	751	692	3138	751
1947-48	960	880	844	802	3486	858
1948-49	873	891	852	836	3452	783
1949-50	918	807	865	925	3515	825
1950-51	982	901	844	916	3643	896
1951-52	968	903	881	897	3649	894
1952-53	1035	883	977	856	3751	916
1953-54	1001	934	952	905	3792	893
1954-55	1012	916	958	890	3866	858
1955-56	926	911	927	890	3654	857
1956-57	946	885	863	828	3522	863
1957-58	970	842	823	808	3443	845
1958-59	975	842	823	808	3448	845
1959-60	975	842	823	808	3448	845
1960-61	975	842	823	808	3448	845
1961-62	975	842	823	808	3448	845
1962-63	975	842	823	808	3448	845
1963-64	975	842	823	808	3448	845
1964-65	975	842	823	808	3448	845
Total	77.12	24.68	24.29	23.91	100.00	

(1) It is apparent that about 30 of these graduates are holders from the previous year.



This table illustrates that, on the basis of past experience, for every first year student, 2.7 other student places must be provided for the combined enrolment in the three subsequent years. When a rapid rise in first year enrolment is projected, however, total enrolment will not immediately increase on a proportionate basis, due to the previously lower first year classes who are now in their second, third and fourth years. For this reason, total enrolment for any period of rapid expansion must be projected on a course-year by course-year basis, taking into account the drop-out from one course-year to another. On the basis of this "drop-out" experience for the past five years, for which final course-year figures are known, these projections would be as shown in Table XII.

16.

TABLE XII

Estimated Total Number of Student Places Required
In Canadian Medical Schools, 1962-63 to 1966-67 and
1970-71 and 1976-77

Academic Year	Year of Course				Total Enrolment	Projected Graduates
	First Year	Second Year	Third Year	Fourth Year		
1960-61(1)	970	842	853	843	3508	845
1961-62	1010(2)	883	811	836(3)	3540	840
1962-63	1065	919	850	796(3)	3630	805
1963-64	1106	969	890	836	3800	820
1964-65	1145	1006	940	869	3960	840
1965-66	1185	1042	975	918	4120	905
1966-67	1225	1078	1006	951	4260	940
1967-68	1265	1115	1045	985	4410	975
1968-69	1305	1150	1075	1020	4550	1010
1969-70	1345	1188	1112	1055	4700	1045
1970-71	1385	1224	1143	1088	4840	1075
1971-72	1430	1260	1187	1123	5000	1110
1976-77	1690				5900	

(1) Actual (2) Preliminary - Canadian Association of Medical Colleges.

(3) These fourth year figures fall slightly short of the number of graduates projected on the basis of 85% of first year enrolment. This is because their drop-out rate in first and second year has been slightly greater than the five year period for which the 85% graduation rate was calculated. This is probably a temporary phenomena which will be corrected.

This table illustrates that, on the basis of past experience, for every first year student, 2.7 other student places must be provided for the combined enrollment in the three subsequent years. When a rapid rise in first year enrollment is projected, however, total enrollment will not immediately increase on a proportionate basis, due to the previously lower first year classes who are now in their second, third and fourth years. For expansion must be projected on a course-year by course-year basis, taking into account the drop-out from one course-year to another. On the basis of this "drop-out" experience for the past five years, for which final course-year figures are known, these projections would be as shown in Table XII.

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1964-65	1145	1006	940	869	3960
1965-66	1185	1042	975	918	4150
1966-67	1225	1078	1006	951	4360
1967-68	1265	1115	1045	985	4510
1968-69	1305	1150	1075	1020	4550
1969-70	1345	1185	1105	1055	4600
1970-71	1385	1224	1143	1088	4840
1976-77	1430	1260	1181	1123	5000
1976-77	1430				5200

(1) Actual (2) Preliminary - Canadian Association of Medical Colleges.
(3) These fourth year figures reflect the number of graduates projected on the basis of 85% of first year enrollment. This is based on their drop-out rate in past years. The graduation rate was 85% in 1966-67. This is probably a temporary phenomenon which will be corrected.



This table must be considered only as an approximation and as a guide to the future. It is designed to give some idea of over-all enrolment capacity requirements during the next decade. It will be noted in this respect that the projected total enrolment in 1962-63 of 3630 would still be less than the maximum of 3686 that has been accommodated in the past. Table XI shows that this level was reached in 1957-58. By 1963-64, however, Canadian medical schools may find their accommodation and teaching facilities somewhat over-extended unless some improvements can be made quickly. It is known that several expansions are now under way or are being planned. The long period of time which is required to put new facilities into operation, however, indicates that urgent action may be needed to meet the projected total requirements in 1971-72 which may exceed present capacity by 35 per cent. It might also be noted in passing, in this discussion, that for every first year professional medical faculty student, the universities as distinct from the medical schools, will have to provide at least two places (one for each year) for pre-medical students.

Conclusion

With all due allowance for an element of inaccuracy in the data here presented, the conclusion is inescapable that the output and capacity of Canadian Medical Schools requires to be increased substantially in the almost immediate future. If this is accepted and regarded as a legitimate objective we must attract to a

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accommodation and teaching facilities somewhat over-extended unless some improvements can be made quickly. It is known that several expansions are now under way or are being planned. The long period of time which is required to put new facilities into operation, however, indicates that urgent action may be needed to meet the projected total requirements in 1971-72 which may exceed present capacity by 32 per cent. It might also be noted in passing, in this discussion, that for every first year professional medical faculty student, the university or college distinct from the medical schools, will have to provide at least two places (one for each year) for pre-medical students.

With all due allowance for an element

of inaccuracy in the data here presented, the conclusion is inescapable that the output and capacity of Canadian Medical Schools requires to be increased substantially in the almost immediate future. If this is accepted and regarded as a legitimate objective we must attract to a



1 career in medicine a higher proportion of academically
2 qualified candidates than are now presenting themselves
3 and the facilities and personnel to train them must be
4 made ready. It is possible that the entry and output of
5 certain existing Canadian schools can be increased and
6 this appears to offer the most likely prospect for early
7 augmentation of the native medical force. In the case of
8 certain of the larger medical schools the optimum size
9 of classes appears to have been reached and the possibility
10 of further expansion is remote.

11 There remains the possibility of
12 establishing new Medical Schools at Canadian Universities
13 where Faculties of Medicine are not now functioning.
14 Long range planning is essential to the implementation of
15 such a proposal and a declaration of need by this Royal
16 Commission on Health Services might encourage certain
17 interested Universities to commence the assembling of
18 money, buildings and above all teachers in the pre-
19 medical, pre-clinical and clinical phases of medical
20 training. The time lag between the decision to establish
21 a new Medical School and the emergence of the first
22 graduate may well be represented by an interval of twelve
23 years. In view of the predictions made in this document
24 on the future needs of this country for doctors, a
25 beginning must shortly be made on several new medical
26 schools.

27 The improvement and expansion of
28 Canada's health services will in large measure depend upon
29 the availability of well qualified physicians. This
30 analysis of the situation in medical manpower as we

the facilities and personnel to train them must be made ready. It is possible that the entry and output of certain existing Canadian schools can be increased and this appears to offer the most likely prospect for early augmentation of the native medical forces. In the case of certain of the larger medical schools the optimum size of classes appears to have been reached and the possibility of further expansion is remote.

There remains the possibility of establishing new Medical Schools at Canadian Universities where Faculties of Medicine are not now functioning. Long range planning is essential to the implementation of such a proposal and a declaration of need by this Royal Commission on Health Services might encourage certain interested Universities to commence the assembling of money, buildings and above all teachers in the pre-medical, pre-clinical and clinical phases of medical training. The time lag between the decision to establish a new Medical School and the emergence of the first graduates may well be represented by an interval of twelve years. In view of the predictions made in this document on the future needs of this country for doctors, a beginning must shortly be made on several new medical

The improvement and expansion of Canada's health services will in large measure depend upon the availability of well qualified physicians. This analysis of the situation in medical manpower as we



forsee it is intended to ensure that services of the highest quality will not be impaired by the lack of the essential medical personnel to operate them.

APPENDIX A

Provincial Aspects of Physician Registration and Supply

The following tables (A1 to A4) are an elaboration on a provincial basis of the national physician-population ratios noted in Table II in the main body of this report. They are derived from the replies to a questionnaire sent to all provincial medical licensing authorities in January, 1961. The tabulation is divided into three parts; for the years 1950 to 1960, as follows:

TABLE A1 - The Total number of doctors registered as of December 31st of each year.

TABLE A2 - New Registrants who were graduates of Canadian Schools,

TABLE A3 - New Registrants who were graduates of Foreign Schools.

The requirements for registration vary slightly from province to province but it may be stated in general terms that candidates for a license to practise medicine must have:

- a) graduated from a recognized medical school
- b) satisfactorily completed one year as an intern in a hospital,
- c) passed the examinations of the Medical Council of Canada or its provincial equivalent,
- d) complied with the ethical and financial requirements of the licensing authority.



force it is intended to ensure that services of the highest quality will not be impaired by the lack of the

Provincial Aspects of Physician Registration and Supply
The following tables (A1 to A4) are

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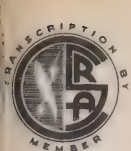
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- d) complied with the ethical and financial require



1 The major exception to this statement
2 of requirements is that persons registered in the "home
3 list", of the General Medical Council of Great Britain
4 may register without further examination in Alberta,
5 Saskatchewan, Manitoba, Nova Scotia, Prince Edward Island
6 and Newfoundland. This circumstance has resulted in a
7 large intake of immigrant physicians from the United
8 Kingdom in the reciprocating provinces.

9 It is significant that in several of
10 the provinces, particularly those which reciprocate with
11 the G.M.C., registration of non-Canadians has exceeded
12 that of Canadian graduates in several of the years under
13 study. The cumulative effect has been to change the
14 medical population of these provinces from one predom-
15 antly Canadian to one in which the medical skills of many
16 nations are very adequately represented.

17 It will be noted in Table A2 that the
18 numbers of new registrants who are graduates of Canadian
19 schools have a tendency to exceed the actual output of
20 graduates from these schools. It is not uncommon for a
21 Canadian doctor to register and maintain his license to
22 practice in more than one province.

23 Likewise, the figures reported by the
24 Registrars for registration of graduates of Foreign
25 schools are higher than those of physician immigration
26 provided by the Department of Citizenship and Immigration
27 in Table V of the main report. This apparent discrepancy
28 reflects the extreme mobility of our immigrant physicians.
29 The statistics for Newfoundland, in particular, and other
30 provinces to a lesser degree indicate that many of these

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The statistics for Newfoundland, in particular, and other

provinces to a lesser degree indicate that many of these



1 physicians stay a relatively short time in their first
2 province for registration and then move on to another
3 province.

4 The table of total registrations
5 (Table A1) as reported by the Registrars, however, records
6 only those doctors who are resident and practising in
7 each province and thus should eliminate those who only
8 register temporarily or who maintain a multiple registra-
9 tion but only practise in one province. That many regis-
10 trations are very transient may be noted by comparing
11 the total number of new registrations - both domestic and
12 foreign - in most provinces in a given year, with the
13 actual increase in the number of doctors in that province
14 in that year, as given in Table A1. The stability of the
15 total registration figures in the face of these somewhat
16 erratic influences gives further support to their validity.

17 TABLE A4 portrays the estimated
18 physician-population ratios in each province at two year
19 intervals from 1950. These are based on the estimated
20 provincial populations as at December 31st of each year.
21 This table shows the relative trends in each province.
22 While the physician-population ratios vary greatly from
23 province to province, there is not a single province in
24 which considerable improvement has not taken place over
25 the past eleven years.

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This table shows the relative trends in each province.

While the physician-population ratios vary greatly from province to province, there is not a single province in which considerable improvement has not taken place over

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20.

Tabulation of Results Received from Questionnaire
Sent to Provincial Medical Licensing Authorities

TABLE A1

Total Fully Registered, Active, Resident Physicians
(December 31st of Each Year)

Province	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Physician Population Ratio Dec. 31, 1960
												1960
Nfld.	154	163	178	200	199	215	228	251	241	275	277	1:1682
P.E.I.	NA	NA	69	81	83	80	83	82	81	80	87	1:1207
N.S.	NA	582	609	NA	642	670	678	703	712	693	719	1:1013
N.B.	337	337	353	360	373	385	378	400	410	431	445	1:1362
Quebec	4,145	4,150	4,311	4,452	4,559	4,793	4,905	5,163	5,397	5,622	5,863	1: 883
Ontario	5,523	5,642	5,822	6,119	6,400	6,704	7,064	7,240	7,409	7,600	7,908	1: 780
Manitoba	775	780	799	833	866	906	912	947	969	1,003	1,033	1: 879
Sask.	633	662	713	750	776	811	835	864	886	925	895	1:1019
Alberta	780	804	863	916	963	995	1,041	1,097	1,141	1,221	1,280	1:1023
B.C.	NA	NA	NA	1,493	1,570	1,662	1,747	1,776	1,850	1,942	2,010	1: 810
Totals	-	-	-	-	16,431	17,221	17,871	18,523	19,096	19,800	20,517	1: 879

TABLE A2

New Registrants - Graduates of Canadian Schools

												Total
Nfld.	23	14	18	15	30	14	29	22	37	27	24	253
P.E.I.	2	3	3	9	1	7	1	3	5	5	5	44
N.S.	30*	31	53	50*	49	39	48	55	40	46	43	484
N.B.	14	30	25	5	21	11	13	14	18	7	23	181
Quebec	235	277	229	235	288	286	235	269	298	274	323	2,949
Ontario	297	305	297	335	304	344	343	307	221	224	266	3,243
Manitoba	59	45	47	48	51	55	45	42	34	38	37	501
Sask.	45	62	63	50	42	47	44	48	40	35	30	506
Alberta	57	49	73	61	47	45	60	48	45	62	72	619
B.C.	86	86	109	91	100	106	91	83	81	93	99	1,025
Totals	848*	902	917	899*	933	954	909	891	819	811	922	9,805

TABLE A3

New Registrants - Graduates of Foreign Schools

												Total
Nfld.	15	29	50	61	94	49	77	53	74	74	83	659
P.E.I.	2	2	1	1	0	0	0	1	2	3	1	13
N.S.	16*	16	18	17*	17	23	34	40	32	42	64	319
N.B.	3	3	1	1	4	5	5	1	3	4	7	37
Quebec	1	0	0	5	13	17	19	51	45	38	35	224
Ontario	52	64	84	125	160	158	179	198	203	192	135	1,550
Manitoba	25	27	37	38	48	42	49	54	49	66	50	485
Sask.	33	44	43	43	41	48	49	69	54	62	50	536
Alberta	34	52	61	59	59	57	50	72	51	57	51	603
B.C.	15	24	44	43	52	48	34	43	44	48	45	440
Totals	196*	261	339	393*	488	447	496	582	557	586	521	4,866

NA-, not available * estimated

Tabulation of Receipts Received from Questionnaire
Sent to Provincial Medical Laboratories

TABLE A1

(December 31st of each year)

Province	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Dec. 31, 1960
N.B.	154	163	178	200	199	215	258	251	241	278	277	277
Quebec	4,145	4,320	4,311	4,402	4,886	4,703	4,908	5,175	5,337	5,415	5,483	5,483
Ontario	2,821	2,810	2,800	2,800	2,800	2,800	2,800	2,800	2,800	2,800	2,800	2,800
Manitoba	775	780	780	780	780	780	780	780	780	780	780	780
Sask.	623	662	773	780	775	811	800	800	800	800	800	800
Alberta	780	804	843	910	963	995	1,000	1,000	1,000	1,000	1,000	1,000
B.C.	NA	NA	NA	1,493	1,500	1,505	1,743	1,730	1,741	1,741	1,741	1,741
Totals	10,278	10,640	10,652	11,071	11,164	11,204	11,408	11,685	11,800	11,845	11,845	11,845

TABLE A2

New Registrations - Graduate or Canadian Schools

Total

Province	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Dec. 31, 1960
N.B.	23	23	14	18	30	14	23	25	27	27	24	252
Quebec	237	237	237	237	237	237	237	237	237	237	237	237
Ontario	207	207	207	207	207	207	207	207	207	207	207	207
Manitoba	29	29	29	29	29	29	29	29	29	29	29	29
Sask.	25	25	25	25	25	25	25	25	25	25	25	25
Alberta	25	25	25	25	25	25	25	25	25	25	25	25
B.C.	86	86	100	100	100	100	100	100	100	100	100	100
Totals	583	583	613	613	613	613	613	613	613	613	613	613

New Registrations - Graduate or Foreign Schools

Province	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Dec. 31, 1960
N.B.	15	15	15	15	15	15	15	15	15	15	15	15
Quebec	15	15	15	15	15	15	15	15	15	15	15	15
Ontario	15	15	15	15	15	15	15	15	15	15	15	15
Manitoba	15	15	15	15	15	15	15	15	15	15	15	15
Sask.	15	15	15	15	15	15	15	15	15	15	15	15
Alberta	15	15	15	15	15	15	15	15	15	15	15	15
B.C.	15	15	15	15	15	15	15	15	15	15	15	15
Totals	90	90	90	90	90	90	90	90	90	90	90	90

NA - Not available * estimated

TABLE A4

Estimated Physician - Population Ratios by Provinces
December 31st, 1950, 1952, 1954, 1956, 1958 and 1960

Prov.	1950		1952		1954		1956		1958		1960	
	Number of Physns.	Physician of Population Ratio	Number of Physns.	Physician of Population Ratio	Number of Physns.	Physician of Population Ratio	Number of Physns.	Physician of Population Ratio	Number of Physns.	Physician of Population Ratio	Number of Physns.	Physician of Population Ratio
Atl.	154	1:2310	178	1:2130	199	1:2020	228	1:1850	241	1:1840	277	1:1682
P.E.I.	70*	1:1390	69	1:1466	83	1:1220	83	1:1190	81	1:1250	87	1:1207
N.S.	566*	1:1130	609	1:1080	642	1:1060	678	1:1030	712	1:1009	719	1:1013
N.B.	337	1:1530	353	1:1500	373	1:1460	378	1:1446	410	1:1420	445	1:1362
Quebec	4,145	1:970	4,311	1:980	4,559	1:980	4,705	1:960	5,357	1:920	5,863	1:883
Ontario	5,523	1:830	5,822	1:840	6,400	1:820	7,064	1:790	7,409	1:800	7,908	1:780
Manitoba	775	1:1000	799	1:1010	866	1:960	912	1:940	969	1:910	1,033	1:879
Sask.	633	1:1310	713	1:1200	776	1:1130	835	1:1050	886	1:1010	895	1:1019
Alberta	780	1:1190	863	1:1150	963	1:1120	1,041	1:1100	1,111	1:1070	1,280	1:1023
B.C.	1,280*	1:900	1,418	1:870	1,570	1:840	1,747	1:830	1,850	1:840	2,010	1:810
Canada (excl. Yukon & N.W.T.)	14,263*	1:975	15,135*	1:968	16,431	1:955	17,871	1:928	19,096	1:905	20,517	1:879

* Estimated.

Sources: C.M.A. Survey of Provincial Licensing Authorities.
Population (not shown): Estimated for December 31, from D.B.S. data.



SUBMISSION OF THE MEDICAL SOCIETY OF NOVA SCOTIA

Appearances: R.F. Ross, M.D., President
A.A. Giffin, M.A., Chairman Special
Research Committee
R.O. Jones, M.D., Member Special Research
Committee
J.A. McDonald, M.D., Member Special
Research Committee
C.B. Stewart, M.D., Member Special
Research Committee
J.W. Reid, M.D., Member Special Research
Committee
C.J.W. Beckwith, M.D., Executive
Secretary

Advisers

A.D. Kelly, M.D., General Secretary
Canadian Medical Association
L.C. Steeves, M.D., Chairman Executive
Committee The Medical Society of N.S.
Mr. S.P. Brannan, General Manager
Maritime Medical Care Inc.

DR. ROSS: We have prepared a brief prepared
by a sub-committee which was appointed a year ago, and
they have been very busy, and in spite of the work they
have done they have not been able to complete all the
studies that they intended. However, we are presenting
this brief, which contains a great deal of information.
The Medical Society of Nova Scotia has long been interested
in medical economics, and 10 years ago we founded the
Maritime Medical Care, which is one of the medical-spon-
sored prepaid plans which you will find throughout Canada.
This plan has been amazingly successful, and at the present
time covers almost one-sixth of the people of Nova Scotia
under a voluntary health plan. It is a non-profit plan,
sponsored and subsidized by the members of the medical
profession. Now, the brief is to be presented to you by
Dr. A.A. Giffin, He is the Chairman of the Research
Committee that we have had working, and he is also



Research Committee
 Secretary

L.G. Stearns, M.D., Chairman
 Committee The Medical Society of U.S.
 Maritime Medical Care Inc.

DR. ROSS: We have prepared a brief prepared

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1 President of Maritime Medical Care. With him we have
2 Dr. Beckwith, Secretary of the Nova Scotia Medical Associa-
3 tion, Dr. R.O. Jones, Professor of Psychiatry at Dalhousie
4 University, and Mr. S. Brannan, who is the Manager of
5 Maritime Medical Care. In addition to that, we have Dr.
6 J.A. McDonald of Glace Bay, representing the general
7 practitioners, and Dr. James Reid, a medical specialist
8 in Halifax. We have also had considerable help in this
9 from Dr. A.D. Kelly, the General Secretary of the Medical
10 Society of Nova Scotia, and we have had assistance from
11 Dr. Steeves, Chairman of the Medical Committee of the
12 Medical Society of Nova Scotia.

13 DR. GIFFIN: Mr. Chairman and Commissioners,
14 at this time we will confine ourselves fairly strictly to
15 the summary and recommendations, but on any point raised
16 in the body of the brief we will try to elucidate when a
17 question is raised.

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question is raised.



A B R I E F

to the

Royal Commission on HEALTH SERVICES

from

THE MEDICAL SOCIETY OF NOVA SCOTIA

(The Nova Scotia Division - Canadian Medical Assoc.)

Presented by:-

R. F. Ross, M.D.	President	Truro, N.S.
A. A. Giffin, M.D.	Chairman Special Research Committee	Kentville, N.S.
R. O. Jones, M. D.	Member Special Research Committee	Halifax, N.S.
J. A. McDonald, M.D.	Member Special Research Committee	Glace Bay, N.S.
C. B. Stewart, M.D.	Member Special Research Committee	Halifax, N. S.
J. W. Reid, M.D.	Member Special Research Committee	Halifax, N. S.
C.J.W. Beckwith, M.D.	Executive Secretary	Halifax, N. S.

Advisers

A. D. Kelly, M.D.	General Secretary Canadian Medical Association	Toronto
L. C. Steeves, M.D.	Chairman Executive Committee The Medical Society of Nova Scotia	Halifax, N.S.
Mr. S.P. Brennan	General Manager Maritime Medical Care Inc.	Halifax, N.S.

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F. ROSE, M.D.

Resd. M.D.

General's Office

A. D. KELLY, M.D.

and 5.60



SUMMARY AND RECOMMENDATIONS

1. Our studies in preparing this brief have impressed on us the extent and multiplicity of the health services which are available in the interests of the patient as an individual and the public as a whole.
2. This section is based on "---- recommending methods of ensuring that the best possible health services be available to all Canadians". We believe that, in the provision of medical services in prevention, diagnosis, treatment and rehabilitation, the physician has been and will be the central factor.
3. Our recommendations relate themselves to our proposals for priorities in the improvement of health services. (Term (k), Page 94). We emphasize, however, that attention to any one element should not be so intense that other essential features are disregarded. In our view improvements should be proceeded with on a broad front. We recognize that neither public nor private financing will permit implementation of all the desirable extensions of health services at one time to their fullest extent. With these considerations in mind we submit the following recommendations.

4. Recommendation 1.

The Training of Health Personnel

Deficiencies in the number of physicians available to serve the needs of the people of Nova Scotia have been disclosed in our studies. We are dependent in large measure

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impressed on us the extent and multiplicity of the
health services which are available in the hospitals
of the patient as an individual and the public as a

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Our recommendations relate themselves to our
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services. (Term (K), Page 29). We emphasize, however,
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intense that other essential features are disregarded.
In our view improvements should be proceeded with on a
broad front. We recognize that neither public nor
private financing will permit implementation of all the
desirable extensions of health services at one time to
their fullest extent. With these considerations in
mind we submit the following recommendations.

Recommendation I.

Deficiencies in the number of physicians
available to serve the needs of the people
of Nova Scotia have been discussed in our
studies. We are dependent in large measure



1
2 on the graduates of the Faculty of Medicine
3 of Dalhousie University for the general
4 practitioners and specialists who practice
5 in this Province. Our first recommendation
6 therefore relates itself to aid to medical
7 education and we propose a capital investment
8 of \$4.5M. of public and private funds to
9 provide for the expansion of the Dalhousie
10 Medical School. Details of the proposal
11 are outlined in the narrative portion of our
12 submission relative to terms (e), Page 67,
13 (f), Page 71, and (g), Page 78.

14 5. The recruitment of medical students must be
15 accelerated. In all its studies and recommendations
16 it is our hope that this Commission will keep in mind
17 that a career in medicine should be made more
18 attractive by reason of any changes proposed.

19 6. The maintenance of adequate facilities for
20 medical education will involve an annual sum of
21 unknown but substantial amount. The support of the
22 only medical school in the Atlantic provinces is
23 worthy of increased financial participation of the
24 four provinces concerned, as well as that of the
25 Federal authority. Grants to medical undergraduates
26 will be necessary to permit them to finance the long,
27 expensive course and to ensure sufficient recruitment
28 of suitable medical students.

29 7. Not less urgent is the need for increased
30 numbers of para-medical workers of all types. In

on the graduates of the Faculty of Medicine

practitioners and specialists who practice

therefore relates itself to aid to medical

education and we propose a capital investment

of \$4.5M. of public and private funds to

provide for the expansion of the National

Medical School. Details of the proposal

are outlined in the narrative portion of our

submission relative to items (a), (b), (c),

(d), (e), (f), and (g), pages 10, 11,

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four provinces concerned, as well as that of the

Federal authority. Grants to medical undergraduates

will be necessary to permit them to finance the long

expensive course and to ensure sufficient recruitment

of suitable medical students.

Not less urgent is the need for increased

numbers of para-medical workers of all types. In



1
2 certain instances, training facilities in the Atlantic
3 provinces will require enlargement and support. In
4 other cases where no facilities exist, the
5 establishment of schools and courses is necessary. On
6 Page 13 (Paras. 43-60), we have outlined the
7 deficiencies as we see them and we recommend the
8 amplification of the Professional Training Grant under
9 the National Health Grants program to assist the
10 training of these essential workers.

11 8. Closely related to the education and
12 training of health workers is medical research and it
13 is evident that the pursuit of new knowledge and better
14 methods is fundamental to the improvement of health
15 services. It is our view that funds for research
16 should be provided largely through continued and
17 increasing support of the Medical Research Council.
18 However, it will be impossible and undesirable to
19 separate completely clinical investigation from medical
20 services or hospital insurance programs. (See Term (j),
21 Page 92.)

22 9. Recommendation 2.

23 The Provision of Physical Facilities for
Improved Health Services.

24 Although we have designated the provision of
25 trained personnel as our primary requirement, con-
26 current action in the provision of physical facilities
27 must go forward. In our appraisal of the situation
28 under term (f), Page 71, we have stated that active
29 and long-term treatment hospitals to a level of 6.9
30

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provinces will require enlargement and support. In

other cases where no facilities exist, the
establishment of schools and courses is necessary. On

Page 13 (paras. 43-60), we have outlined the
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is evident that the pursuit of new knowledge and better

methods is fundamental to the improvement of health

services. It is our view that funds for research

should be provided largely through continued and

increasing support of the Medical Research Council.

However, it will be impossible and undesirable to

separate completely clinical investigation from medical

services or hospital insurance programs. (See Term 1.)

(See 62.)

The Provision of Physical Facilities for Improved Health Services

Although we have designated the provision of

current action in the provision of physical facilities

must go forward. In our appraisal of the situation

under term (1), we have stated that active

and long-term treatment hospitals to a level of 0.5



1
2 beds per 1000 of our population is a valid objective.
3 We recommend that the construction of 1,170 additional
4 active treatment beds be proceeded with and we
5 estimate the capital cost of construction to be
6 approximately \$23.4M.

7 10. The construction of 920 beds for the care
8 of convalescent, chronic and terminal patients,
9 preferably located in close relationship to active
10 treatment hospitals, is also necessary. We estimate
11 the construction cost of these facilities to be \$9.2M.

12 11. We further recommend that a rehabilitation
13 centre be constructed at an approximate cost of \$3M.,
14 that community health centres be provided in areas of
15 need, that facilities for mental health clinics be
16 considerably amplified and that a hostel for the
17 accommodation of patients attending the Nova Scotia
18 Tumor Clinic be constructed. We estimate the capital
19 cost of the latter three facilities to be of the order
20 of \$350,000.

21 12. The implementation of our recommendation for
22 the reform of the mental health services will
23 unquestionably require the replacement of facilities
24 but we are not at this time prepared to estimate the
25 cost involved.

26 13. We fully appreciate that expenditures of
27 considerable magnitude will be required to bring our
28 present health facilities up to a reasonable standard
29 of adequacy and that their maintenance will involve
30 substantial annual outlays.

beds per 1000 of our population is a valid objective.
We recommend that the construction of 1,170 additional
active treatment beds be proceeded with and we
estimate the capital cost of construction to be
approximately \$23.4M.

The construction of 920 beds for the care
of convalescent, chronic and terminal patients,
preferably located in close relationship to active
treatment hospitals, is also necessary. We estimate
the construction cost of these facilities to be \$14.2M.
We further recommend that a rehabilitation
centre be constructed at an approximate cost of \$1M.

need, that facilities for mental health clinics be
considerably amplified and that a hostel for the
accommodation of patients attending the Nova Scotia
Tumor Clinic be constructed. We estimate the capital
cost of the latter three facilities to be of the order
of \$350,000.

The implementation of our recommendations for
the reform of the mental health services will
undoubtedly require the replacement of facilities
but we are not at this time prepared to estimate the
cost involved.

We fully appreciate that expenditures of
considerable magnitude will be required to bring our
present health facilities up to a reasonable standard
of adequacy and that these expenditures will involve



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14. Our thoughts on methods of financing are outlined in the comment under term of reference (1), Page 80.

15. Recommendation 3.

Universally Available Voluntary Medical Services Insurance

We have spelled out in considerable detail that comprehensive medical services insurance should be available to every resident of Nova Scotia regardless of age, state of health or financial status. (Page 39, Para. 140), (Page 63, Para. 210).

16. We recommend that for 100,000 of our fellow citizens who may be classified as indigent, the total cost of such services be paid from public funds. For those above this level of economic status, who can prove need, we suggest that assistance be provided to enable them to purchase the coverage which they require. For the self-supporting majority, we recommend that they be encouraged to continue to be responsible for personal health services by insurance coverage or from their own resources. (Pps. 90-91).

17. We recommend that one or more approved carriers of medical services insurance be identified and that the plan be subsidized to the degree required to provide service to the groups already mentioned and to permit the enrolment of individuals of any age or state of health.

18. We have estimated that the cost of providing comprehensive medical insurance coverage to the

14.

Our thoughts on methods of financing are outlined in the comment under item of reference (1).

Universally Available Voluntary Medical Services Program

We have spelled out in considerable detail

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require. For the self-supporting majority, we recommend that they be encouraged to continue to be responsible for personal health services by insurance coverage or

16.

We recommend that one or more approved carriers of medical services insurance be identified and that the plan be subsidized to the degree required to provide service to the groups already mentioned and to permit the enrollment of individuals of any age or state of health.

17.

We have estimated that the cost of providing comprehensive medical insurance coverage to the

1
2 "medically indigent" would be \$2.5M per year.

3 19. No estimate has been made of the cost of
4 subsidizing those who require partial assistance or
5 the extra cost of enrolling those over 65.

6 20. Recommendation 4.

7 Reform of the Programs on Mental Health
8 Services,
9 Rehabilitation and Cancer Control

10 At Paragraphs 104-112, Page 27, we have
11 commented on the services available to the population
12 in the field of mental health, and many deficiencies
13 have been pointed out. In our view, there is urgent
14 need for a new approach to the problems of mental ill-
15 health, particularly with respect to institutional
16 services.

17 21. Twelve recommendations are presented which
18 are designed to accomplish the necessary reform.
19 (Page 32, Para. 128). It has not been possible to
20 estimate the cost of the improvements which we propose
21 but they will undoubtedly involve a considerable outlay
22 of public funds.

23 22. The rehabilitation of the sick and injured
24 may be regarded as a neglected area of health services
25 and the facilities available in Nova Scotia represent
26 nothing more than a beginning. We have discussed the
27 essentials of an adequate service and have incorporated
28 several recommendations to achieve it. (Page 39,
29 Para. 141; Page 40, Para. 143). Aside from a
30 recommended expansion of the facilities of the Nova

"medically indigent" would be \$2.5M per year.

No estimate has been made of the cost of subsidizing those who require partial assistance or the extra cost of enrolling those over 65.

Recommendation 4.

Return of the Program on Mental Health Services.

At Paragraphs 104-112, Page 47, we have

commented on the service available to the population in the field of mental health, and many deficiencies have been pointed out. In our view, there is urgent need for a new approach to the problems of mental health, particularly with respect to institutional

Twelve recommendations are presented which

are designed to accomplish the necessary reform.

Para. 128. It has not been possible to

estimate the cost of the improvements which we propose

but they will undoubtedly involve a considerable outlay

of public funds.

The rehabilitation of the sick and injured

may be regarded as a neglected area of health services

and the facilities available in Nova Scotia represent

nothing more than a beginning. We have discussed the

essentials of an adequate service and have incorporated

Para. 141; Para. 143. Aside from a

recommended expansion of the facilities of the Nova



Scotia Rehabilitation Centre at an estimated cost of \$3M., we have not undertaken to project the expenditures necessary to provide adequate rehabilitation services throughout the Province.

23. Through the operation of the Nova Scotia Tumor Clinic an impressive start has been made in the diagnosis of cancer and its treatment by radiotherapy and surgery. Improvements in the service of cancer control and its extension throughout the Province are discussed on Page 34, Paras. 138-145, and we recommend as an initial step the establishment of a hostel for the accommodation of patients attending the Nova Scotia Tumor Clinic to spare the use of active treatment beds. An expenditure of \$100,000 for this purpose would in the long run prove economical.

24. Recommendation 5. Public Health. The foregoing recommendations each have a bearing on the public health. The Department of Public Health of Nova Scotia is an integral component in the provision of health services. There are the areas of health care which require a co-ordinated approach by the Department of Public Health, the medical profession and other interested bodies. We recommend that the following be considered in this context: - cardio-renal disease, traffic accidents, rheumatic diseases, maternal and perinatal health, child health, health of the aged and

lism.

perinatal health, child health, health of the aged and traffic accidents, rheumatic diseases, maternal and be considered in this context: - cardio-renal diseases, interested bodies. We recommend that the following of Public Health, the medical profession and other which require a co-ordinated approach by the Department health services. There are the areas of health care Scotia is an integral component in the provision of health. The Department of Public Health of Nova recommendations each have a bearing on the public Recommendations. Public Health. The foregoing purpose would in the long run prove economical. treatment beds. An expenditure of \$100,000 for this Scotia Tumor Clinic to spare the use of active the accommodation of patients attending the Nova as an initial step the establishment of a hostel for discussed on page 34, paras. 138-145, and we recommend control and its extension throughout the Province and surgery. Improvements in the service of cancer Tumor Clinic an impressive start has been made in the Through the operation of the Nova Scotia rehabilitation services throughout the Province. expenditures necessary to provide adequate \$3M., we have not undertaken to project the



25. Recommendation 6.

Miscellaneous Improvements.

In our appraisal of the health services currently available in Nova Scotia, we have encountered situations where improvements should be instituted without fundamental change in the character of the service itself. In this category we recommend:

- (a) the better identification of eligible patients under the Indian Health Services and the promulgation of a more realistic schedule of medical fees.
- (b) the institution of freedom of choice of doctor by entitled Sick Mariners in place of the Port Physician system.
- (c) the extension of the current public program for the provision of drugs to the chronically ill, to include patients who are not under institutional care, including the mentally ill, the patients under the cancer programs and those who are being rehabilitated.
- (d) that the beneficiaries under the Federal Civil Servants Group Surgical Medical Insurance Plan be afforded a choice of carrier. If groups decide that the service benefits available under plans such as Maritime Medical Care are preferable, then the employer's

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under plans such as Maritime Medical Care are preferable, then the employers



contribution and the privilege of
payroll deduction should be applicable
(Page 23, Para. 93).

26. Finally, Mr. Chairman, we wish to express
to you and the Commissioners our full appreciation
of the magnitude and importance of the task which,
as a Royal Commission, you have undertaken. In the
time available since the announcement of your terms
of reference we have assiduously applied ourselves to
a study of each item, resulting in the foregoing
recommendations and the narrative which follows. The
results of certain studies already initiated will
be made available to you as soon as possible.

27. The Medical Society of Nova Scotia wishes
you well in your inquiries and the formation of your
recommendations and is prepared to offer your
Commission any assistance of which we are capable.

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(Page 25, Para. 25.)

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B R I E F

from

THE MEDICAL SOCIETY OF NOVA SCOTIA

(Nova Scotia Division of the Canadian Medical Association)

to

THE ROYAL COMMISSION ON HEALTH SERVICES

1961

INTRODUCTION

Mr. Chairman and members of the Royal Commission on Health Services,

28. The Medical Society of Nova Scotia, which is the Nova Scotia Division of the Canadian Medical Association, bids you a cordial welcome to Nova Scotia. It is of interest to note that the first provincial hearing of this Royal Commission takes place in this Province, since the Medical Society of Nova Scotia is the senior medical association in Canada, having been founded in 1854 and having held its 108th consecutive Annual Meeting in June, 1961.

29. Created in 1854, in the interests of protecting and improving standards of medical care, the membership has continually sought the ideal of providing a high quality of medical services under the varying circumstances identified with this Province. The Society, which now has 636 members, is fully conscious of its responsibilities in the realm of prevention of disease and the diagnosis,

THE MEDICAL SOCIETY OF NOVA SCOTIA

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1
2 treatment and rehabilitation of the patient with
3 disease.

4 30. The members, all of whom join the Society
5 and maintain membership on a purely voluntary basis,
6 are also voluntarily active in the encouragement of
7 and assistance to the many fields of endeavor, public
8 and private, which provide services ancillary to
9 those provided by the physician for the benefit of
10 the patient.

11 31. As the Nova Scotia Division of the Canadian
12 Medical Association, the Medical Society of Nova
13 Scotia has had close association with the national
14 scene involving medical and allied health services.
15 The beliefs and principles as expressed by the
16 Canadian Medical Association (1960) are supported by
17 this Division as a basis for the development of
18 medical services insurance in Canada. (Appendix I,
19 Page 97).

20 32. We in this Province have participated in the
21 modern development of scientific medicine, we have
22 co-operated with official and voluntary agencies to
23 bring the advances to our people, we have improved
24 the quality of medical care and we have established
25 under our own auspices a successful plan of prepaid
26 medical insurance. The objects of our Society and
27 the Committees by which we attempt to attain them,
28 are outlined in Appendix II, Page 100. We recognize
29 that health services of high quality are regarded as
30

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The members, all of whom join the Society and maintain membership on a purely voluntary basis, are also voluntarily active in the encouragement of and assistance to the many fields of endeavor, public and private, which provide services ancillary to those provided by the physician for the benefit of the patient.

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We in this Province have participated in the modern development of scientific medicine. We have co-operated with official and voluntary agencies to bring the advances to our people, we have improved the quality of medical care and we have established under our own auspices a successful plan of prepaid medical insurance. The objects of our Society and the Committee by which we attempt to attain them are outlined in Appendix II, Page 100. We recognize that health services of high quality are regarded as



essential in our society, as is attested by the following resolution passed in 1960 at our 107th Annual Meeting:

"that the Medical Society of Nova Scotia at this general meeting (1960) goes on record and is in accord with a plan for medical services insurance in Nova Scotia so that the highest possible quality of medical services will be available irrespective of income; and furthermore, the Medical Society of Nova Scotia believes that this can be brought about by the united efforts and co-operation of existing agencies interested in and responsible for the health of the people of Nova Scotia".

33. In the autumn of 1960 we established a Special Research Committee to implement our belief and we have outlined in Appendix III, Page 102 the terms of reference of that committee of five members. It will be observed that our field of study bears a close resemblance to that assigned to the Royal Commission. We have advised the leaders of all political parties in the Legislature of Nova Scotia of our undertaking because we recognize that the co-operation of legislators and the medical profession will be required to attain the level of health service which will be needed.

34. The gratifying announcement by the Prime Minister of Canada in December 1960 that a Royal Commission on Health Services would be appointed, resulted in our Executive Committee delegating to the Special Research Committee the responsibility to prepare a submission for the Royal Commission for the approval of the Medical Society. Studies had been

essential in our society, as is attested by the following resolution passed in 1960 at our 107th

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1
2 initiated under the terms of reference to the Special
3 Research Committee, but since the announcement of
4 the terms of reference of the Royal Commission on
5 June 20th, 1961, we have framed our investigations
6 with your requirements in mind.

7 35. The necessity and desirability of having
8 health services available to all residents of Nova
9 Scotia creates no issue; we are entirely in
10 agreement. The point for examination and decision
11 is how the objective is to be achieved. This, we
12 submit, requires the closest examination. Medical
13 "needs" in contrast to medical "wants" will have to
14 be determined. Within Nova Scotia there are varying
15 regional problems, in some instances strikingly
16 similar to variations across Canada.

17 36. There are many services developing and
18 contemplated which must be considered as necessary
19 for a solid foundation in order to assure the full
20 implementation of the potential of health services
21 to residents.

22 37. The highest possible quality of medical
23 services cannot be purchased as a piece of
24 merchandise. Nothing is as personal as the service
25 which a physician provides to his patient. Such
26 service, projected by the physician in whatever field
27 of endeavor he may choose, results from a combination
28 of medical training and medical research which is
29 initiated in student days and continued throughout
30 his lifetime. The utilization of this knowledge

initiated under the terms of reference to the Special Research Committee, but since the announcement of the terms of reference of the Royal Commission on the Health Services, the Special Research Committee has been asked to continue its work.

35. The necessity and desirability of having health services available to all residents of Nova Scotia creates no issue; we are entirely in agreement. The point for examination and decision is how the objective is to be achieved. This, we submit, requires the closest examination. Medical "needs" in contrast to medical "wants" will have to be determined. Within Nova Scotia there are varying regional problems, in some instances strikingly similar to variations across Canada.

36. There are many services developing and contemplated which must be considered as essential for a solid foundation in order to assure the full representation of the potential of health services to residents.

37. The highest possible quality of medical services cannot be guaranteed as a place of residence. Working as a personal as the service within a region provides to its residents, such service, protected by the physician in whatever field of endeavor he may choose, results from a combination of medical training and medical research which is initiated in student days and continued throughout his lifetime. The utilization of this knowledge



1
2 assimilated by the physician in the fields of
3 prevention , diagnosis, treatment and rehabilitation
4 is a personal responsibility proudly assumed by the
5 great majority of physicians.

6 38. From time to time continued progress in
7 scientific and social affairs requires a pause to
8 examine the numerous factors involved and an attempt
9 to orient them to take full advantage of their
10 potential. Health services are essential. We
11 welcome this opportunity, along with other interested
12 groups, to make an objective review of these matters
13 following your extensive terms of reference. We are
14 of the belief that we have a mutual objective in
15 such a study which is to assure the residents of
16 Canada, and, from our viewpoint particularly Nova
17 Scotia, that the highest possible quality of health
18 services are available to all to maintain health, to
19 prevent disease and when disease does occur, early
20 diagnosis, adequate treatment and rehabilitation.
21 We submit that the central factor in this area is the
22 medical service provided to patients by physicians.

23 39. The preceding recommendations are based on
24 the information included in the accompanying
25 submission. In it we have dealt with each term of
26 reference based on information available to us.
27 Unfortunately, the interval between the announcement
28 of the terms of reference (June 20th, 1961) and the
29 date it was necessary to finalize the brief
30

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of the terms of reference (June 1961, 1961) and the
case it was necessary to finalize the brief



(October 15th, 1961) is such that we do not have available all the detailed information we would wish to present to you. Our comments will relate to each of your specific terms of reference.

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to present to you. Our comments will relate to
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1
2 TERM (a) "THE EXISTING FACILITIES AND METHODS FOR
3 PROVIDING PERSONAL HEALTH SERVICES,
4 INCLUDING PREVENTION, DIAGNOSIS, TREATMENT
5 AND REHABILITATION."

6 40. Within this term of reference, the physician
7 licensed to practice medicine, is the hub in the
8 provision of personal health services. It is the
9 physician who initially or ultimately has the
10 responsibility for the prevention, diagnosis,
11 treatment of disease and for rehabilitation of the
12 patient.

13 41. In preparation for these responsibilities,
14 students of medicine are required to have three
15 years of university training preparatory to
16 eligibility to make application for the study of
17 medicine. He makes application for admission to a
18 School of Medicine and if his academic record and
19 other factors warrant, he is admitted to the Medical
20 School where an intensive period of study, application,
21 and observation by his teachers results in the
22 demonstration of capabilities to sit for his final
23 examinations in the Medical School and for his license
24 to practice medicine. This requires a period of five
25 years, the successful result of this eight years
26 study being evident by the awarding of the degree of
27 Doctor of Medicine and a license to practice.

28 42. At this point in the physician's development
29 there lies before him the choice of many fields in
30 which he may apply his knowledge and his skill. One
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THE NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE UNITED STATES OF AMERICA
WASHINGTON, D. C.

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2 represents the area of service adopted by the
3 majority of physicians which is fundamental to
4 personal health services.

5 43. The Provincial Medical Board* is the
6 custodian of the Medical Act of Nova Scotia and the
7 licensing body for that Province. Examination of
8 this register indicates that there are 809 physicians
9 registered in Nova Scotia as licensed to practice.
10 (Table #1, Page 134). 597 of these are specifically
11 in the private practice of medicine; 385 are
12 classified as being in active general practice, and
13 212 in specialty practice (Table 2, Page 135).

14 44. At this point, we would recommend that the
15 term "medical services" be confined particularly to
16 services provided by physicians licensed to practice
17 medicine. Such medical services rendered by physicians
18 are, of course, only one of the many health services
19 available for the benefit of the patient and the
20 public health. Nevertheless, in our view, to group
21 all health services under the caption of "Medical
22 Services" would be an error and would tend to confuse
23 the examination under weigh. For example, within
24 the total cost of all services, that of the
25 physician's services is small, being less than one-
26 third of the amount spent on all health care.

27 45. "The physician's relationship to health
28 services may be broadly divided into 2 categories

29 * For Brief History See Appendix IV, Page
30

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2 (a) services rendered to patients individually and
3 directly under conditions of private practice as we
4 know it and (b) services rendered indirectly or
5 collectively. Both approaches are essential to well
6 balanced health services".*

7 46. We consider the family unit to be the basis
8 of modern society. We also believe that the family
9 physician, fully aware of his medical competence as
10 well as his limitations, and with consultants
11 available, can provide high quality personal medical
12 services. The physician in providing his services
13 to the patient, may well be influenced by family
14 situations and problems. The majority of illnesses
15 can be dealt with by a single physician, whether he
16 be a general practitioner or have additional
17 qualifications.

18 47. The inter-relationship between the patient,
19 the family and the physician is all-inclusive and is
20 best visualized by the concept of psychosomatic
21 medicine, implying the relationship of mental health
22 and bodily health. Thus the services provided by the
23 physician to the patient are truly personal. To
24 fulfil them, the individual physician employs his own
25 talents, or having recognized that an additional
26 opinion is required, will call on another physician
27 or physicians to assist him. Indeed, the practising
28 physician has at his disposal, either locally or
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30 *Some Characteristics of the Medical Profession of Canada
C.M.A.

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1
2 actual practice of medicine which are necessary to
3 the patient.

4 48. Specialists. Nova Scotia does not have a
5 specialist register. Certification or fellowship,
6 awarded by the Royal College of Physicians and
7 Surgeons of Canada, based on adequate post-graduate
8 training and granted after successful examination, is
9 the official recognition of specialist status. It
10 is on this basis that 212 physicians are classified
11 as being in specialty practice in Nova Scotia. (See
12 Table#II, Page 135). Halifax, being a centre of large
13 population, having the Dalhousie Medical School, and
14 being a medical centre for Nova Scotia (and a large
15 degree the Atlantic Provinces), has the majority
16 of specialists. Elsewhere specialty practice is
17 found scattered in urban areas particularly where
18 hospital facilities are available. There is little
19 doubt that, as the hospitalization program develops
20 in the Province, physicians with specialist training
21 will be attracted to communities because of the
22 improving facilities available to them. Even at the
23 present time, the existing facilities are such that
24 the great majority of individuals have access to
25 specialty services because of the relative ease of
26 transportation. For example, patients who require
27 treatment for cancer have their transportation paid
28 for to and from Halifax, whereas the Medical Society
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has an Obstetrical Emergency Team centered in
Halifax, which is on 24 hour call and can be
transported to any area within the Province.

49. The Medical Society of Nova Scotia has not
been able to find any figures on the distribution
of physicians' services in relationship to geography,
population and facilities for Nova Scotia. Our
Special Research Committee has developed a "Community
Medical Manpower Questionnaire" which has been
distributed to a physician in each of approximately
80 communities. (See Appendix V, Page 107). We are
not yet ready to report this study, but we plan to
file it with the Royal Commission when it is
completed.

50. The College of General Practice of Canada
has instituted a survey of General Practice, but due
to lack of funds, has confined this survey to the
provinces of Nova Scotia and Ontario only. The
comprehensive nature of this survey is indicated by
the first tentative table of contents. (Appendix VI,
Page 108).

51. It is a characteristic of the private
practice of medicine that the personal responsibility
of the physician to his patient is a fact in law.
The legal relationship is therefore an implied
contrast between patient and doctor. As a
development from this, the freedom of the patient to
choose his doctor, and the freedom of the doctor to
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1
2 is an established usage, which time has proven to be
3 eminently successful. This has resulted from the
4 very personal nature of the relationship.

5 52. Our Special Research Committee recognized
6 that those receiving personal health services (the
7 patients), have their own point of view. In an
8 endeavor to ascertain what this may be, including
9 medical services available, a "Community Questionnaire"
10 has been prepared. (Appendix VII, Page 110). This
11 has been directed to twenty-one communities, selected
12 at random, in each of which a member of between 100
13 and 200 households will be interviewed. We believe
14 the results will provide pertinent information and
15 the data will subsequently be submitted to the Royal
16 Commission.

17 53. These two Special Research Committee studies
18 are designed to ascertain the present availability
19 of personal medical services in the field of private
20 practice, the distribution as well as the implied and
21 actual unmet needs. Together with the Report of the
22 Survey of General Practice in Nova Scotia, we expect
23 to have considerable factual information not
24 available elsewhere, which will be applicable to the
25 geography and distribution of population in Nova
26 Scotia.

27 54. Even with this material available, the
28 subject may well prove to be one in which the further
29 study by the Commission's Research Department would
30 be desirable. We would indeed be pleased to

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Even with this material available, the

subject may well prove to be one in which the further

study by the Commission's Research Department would

be desirable. We would indeed be pleased to



co-operate.

55. In the meantime, from such information as we have, we believe that personal medical services are reasonably adequate to fulfil "medical needs" in the cities and towns of Nova Scotia as well as many of the villages. Our concern lies in the rather scattered rural areas which characterize Nova Scotia. We expect our community survey to indicate those which should have more adequate medical services available. It is not only difficult to attract a physician to many rural communities under existing conditions, but there may be little incentive to expect him to remain. Occasionally an attempt has been made to attract a doctor by having available a house and office for him. There are three communities in the Province where the Government of Nova Scotia participates in providing personal medical services through subsidization of the physician. These principles have our complete endorsement.

56. We believe there is a solution to this perennial problem. It is that the area provide a Community Health Centre which would provide the physician with office space, the necessary equipment and facilities to conduct his practice. We would visualize the community having a Board responsible for the centre, together with its services, and that the physician would pay rent for its use. The community, with or without government assistance, would thereby have an active interest in the

501

In the meantime, from such information as we have, we believe that personal medical services in the cities and towns of Nova Scotia as well as in the villages. Our concern lies in the rather scattered rural areas which characterize Nova Scotia. We expect our community survey to indicate those which should have more adequate medical services available. It is not only difficult to attract a physician to many rural communities under existing conditions, but there may be little incentive to expect him to remain. Occasionally an attempt has been made to attract a doctor by having available a house and office for him. There are three communities in the Province where the Government of Nova Scotia participates in providing personal medical services through subsidization of the physician. These principles have our complete endorsement. We believe there is a solution to this general problem. It is that the area provide a Community Health Centre which would provide the physician with office space, the necessary equipment and facilities to conduct his practice. We would visualize the community having a Board responsible for the centre, together with its services, and that community, with or without government assistance, would thereby have an active interest in the

50.



1
2 provision of medical services and the doctor would
3 have facilities for prevention, diagnosis and
4 treatment without the personal financial
5 responsibility of procuring them in areas where
6 income is expected to be low. An extension of the
7 principle could include an office for a public health
8 nurse in the centre. It is visualized that Community
9 Medical Health Centres could be constructed and
10 equipped to a minimum standard, beyond which each
11 could be developed according to the desires and
12 resources of the community. We submit that the
13 desire to decentralize medical services merits close
14 examination of the principle of the Community Health
15 Centre.

16 57. Para-medical Personnel. The professions of
17 dentistry and of veterinary medicine provide health
18 services in their own right. Sanitary inspectors
19 and engineers contribute to the whole health care
20 program but their services are considered to be
21 outside the scope of this submission. Comments on
22 the more important classes of para-medical personnel
23 follow. (Appendix X, Page 118).

24 58. Registered Nurses. The universities in Nova Scotia
25 providing degree courses in nursing are listed in
26 Appendix XI, Page 119). In addition there are
27 fourteen nurses' training schools in Nova Scotia
28 in association with hospitals. (Appendix XI, Page 119).
29 These vary in the calibre of training as evidenced
30 by the fact that certain hospitals have a much higher

provision of medical services and the doctor would have facilities for prevention, diagnosis and treatment without the personal financial responsibility of procuring them in areas where income is expected to be low. An extension of the principle could include an office for a public health nurse in the centre. It is visualized that Community Medical Health Centres could be constructed and equipped to a minimum standard, beyond which each could be developed according to the desires and resources of the community. We submit that the desire to decentralize medical services merits close examination of the principle of the Community Health Centre.

Para-medical Personnel. The professions of dentistry and of veterinary medicine provide health services in their own right. Sanitary inspectors and engineers contribute to the whole health care program but their services are considered to be outside the scope of this substation. Comments on the more important classes of para-medical personnel are given in the following table.

Registered Nurses. The universities in Nova Scotia providing degree courses in nursing are listed in Appendix XI, Page 119. In addition there are various other training courses in this field in association with hospitals. (Appendix XI, Page 119). These vary in the calibre of training as evidenced by the fact that certain hospitals have a much higher



1
2 portion of their trainees pass the Registered
3 Nurses' examinations at the first attempt. With
4 hospitalization insurance it appears probably that
5 the utilization of nursing personnel will be
6 improved for the hospitals are not the employers
7 rather than private individuals so that the services
8 of special nurses can be spread over a larger number
9 of patients. Despite this, the proposed expansion
10 of hospital beds is going to aggravate the present
11 shortage of Registered Nurses. At present there
12 are approximately 2,600 nurses in the Province
13 engaged in nursing. It is estimated that an
14 additional 700 nurses would be required.

15 59. Certified Nursing Assistants. These are trained
16 locally in four schools and we believe that their
17 course of training is satisfactory. 1,340 have been
18 granted recognition as certified and are presently
19 employed in the hospitals of Nova Scotia. It is
20 estimated that a further 400 will be required to
21 help staff the planned increase in hospital beds.

22 60. Orderlies. In the past many of these have been
23 trained at Camp Hill Hospital under the auspices of
24 the Department of Veterans' Affairs. We believe that
25 there is a trend toward such personnel seeking
26 recognition as certified nursing assistants. This we
27 would encourage by recommending the provision of
28 suitable courses and facilities to enable them to
29 qualify. They already play a very important part in
30 the care of hospitalized patients and could be trained

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1
2 for special employment. For example, they can be
3 adapted to the care of the chronically ill and they
4 could serve very special functions in rehabilitation
5 centres and in the orthopaedic departments of general
6 hospitals.

7 61. Prosthetists (brace and appliance makers). These are
8 not trained in the Province and are in extremely
9 short supply; the need is critical.

10 62. Physiotherapists and Occupational Therapists. These
11 are at present trained in other parts of Canada by
12 universities and in other parts of the world by
13 hospitals. They have at least two years of university
14 training which is fairly satisfactory. The need for
15 such therapists has multiplied over the last seven
16 or eight years and can be expected to double in the
17 next five years as a result of opening physiotherapy
18 departments in numerous regional hospitals and
19 smaller hospitals. An increase in the number of
20 mobile physiotherapy units is predicted. The
21 experience has been that wherever a physiotherapist
22 is placed in a town, perhaps on a part-time basis,
23 it is a very short time before her services are over
24 utilized and there is need for a further supply. It
25 is anticipated that Dalhousie University will enter
26 the field of training physiotherapists and
27 occupational therapists as soon as space becomes
28 available for their clinical training and this is
29 largely contingent on the building of a new
30

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rehabilitation centre. This is long overdue despite strenuous efforts on the part of the medical profession to bring it about.

63. Psychologists. These are trained locally at universities and we believe their training is satisfactory; they are in very short supply. We are primarily interested in the clinical psychologists who are utilized primarily for the testing of patients though occasionally they undertake therapy under the direct supervision of a psychiatrist.

64. Vocational Counsellors. No formal training course exists for these in Canada and it is an occupation which has an expanding area of usefulness as medicine becomes interested in vocational rehabilitation of a patient. These require to be dedicated and mature individuals who are interested in the personal problems of those who they serve and who must also have an intimate knowledge of the requirements of employers and required skills in various settings.

65. Medical Record Librarians. These are trained locally and are in extremely short supply. There is going to be an expanding need because of the increase in hospital beds.

66. Hospital Administrators. In Nova Scotia these are largely laymen with training in accountancy. In the larger hospitals the administrators are medical men. Advanced courses in hospital administration are

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larger hospitals the administrators are medical men.

Advanced courses in hospital administration are



1
2 offered by several of the larger Canadian
3 universities.

4 67. Medical Social Workers. These are trained in Nova
5 Scotia at the Maritime School of Social Work in
6 Halifax. They are in short supply.

7 68. Dietitians. Within the Province adequate courses in
8 Dietetic Science are offered by the universities.
9 The graduates are in short supply.

10 69. Health Educators. There is no training for these
11 in Nova Scotia. Their role is played by the teachers
12 qualified in physical education working in the
13 schools or through the physical fitness program of
14 the Department of Education.

15 70. X-ray Technicians and Isotype Technicians. These
16 are trained locally in X-ray diagnostic and X-ray
17 therapeutic procedures and we believe their training
18 to be satisfactory. They are in short supply.

19 71. Laboratory Technicians. These are trained locally
20 and we believe satisfactorily. They are in short
21 supply.

22 72. Specialized Technicians. Technicians trained in
23 electroencephalography, angiocardiology, medical
24 photography and personnel for the operation and
25 maintenance of heart pumps, are trained elsewhere and
26 are in short supply.

27 73. Speech Therapists. These are trained outside the
28 Province primarily as a responsibility of the
29 universities although often in special settings such
30 as rehabilitation centres and schools for the deaf.

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1 They are very much in demand and are in very short
2 supply.

3 74. This review of para-medical personnel
4 indicates the several areas of special training
5 required, the inadequate numbers trained to meet
6 present requirements and the necessity of increased
7 facilities for training and recruitment.

8 75. Voluntary Insurance for Medical Services. In keeping
9 with the philosophy of the medical profession, that
10 insurance to prepay the costs of medical services
11 should be available to all regardless of age, state
12 of health or financial status, the doctors of Nova
13 Scotia organized Maritime Medical Care Incorporated
14 in 1948 (Appendix VIII). This prepaid non-profit
15 medical plan is supported by 99% of the profession
16 engaged in active practice. During the thirteen
17 years of existence, the numbers of subscribers have
18 increased from 23,000 to 140,000.

19 76. The majority of these subscribers have the
20 financial resources to pay the premium directly.
21 9,832 in receipt of financial assistance by
22 government have premiums paid through an agreement
23 of the Medical Society with the Department of Public
24 Welfare of the Province. The agreement has been
25 operative since 1950 (Appendix IX). An examination
26 of the agreement shows that the doctor rendering
27 the personal services subsidizes the plan to
28 considerable extent in accepting less than the
29 current schedule of fees and by providing services
30 to the welfare recipient beyond the scope of the

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1 agreement for which he makes no charge. In short,
2 the medical needs of this group are met, but the
3 costs are not.

4 77. A beginning in meeting the problems of the
5 medical care of the aged was made in Nova Scotia
6 with the inauguration of the "Seniors Health Plan"
7 in 1960 (Appendix VIII).

8 78. The role of the private practitioner in the
9 initiation and development of voluntary insurance
10 for medical services has been and is of fundamental
11 importance in the success of any such program. It
12 is based upon freedom of thought, freedom of speech,
13 freedom of action and freedom of choice on matters
14 medical. These safeguards are incorporated in
15 prepaid medical care plans, sponsored and/or
16 supported by the medical profession and are assured
17 in those plans controlled by the profession.
18 Subscribers' rights and privileges are doubly
19 supervised by non-medical representation on Boards
20 of Directors of such plans.

21 79. The medical profession also has been
22 instrumental in developing Trans-Canada Medical Plans
23 for the purpose of making available the principle of
24 non-profit prepaid medically sponsored comprehensive
25 services across Canada.

26 80. It is visualized as being the co-ordinating
27 body to arrange national coverage for employers who
28 have Trans-Canada interests.

29 81. Trans-Canada Medical Plans does act as
30 co-ordinator for the eleven plans at present in

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operation in the development of common statistical information and uniform contracts.

82. It has the potential to become a national underwriting agency for the processing of benefits to supplement prepaid medical plans.

83. We know of no commercial carrier that provides a comprehensive level of medical services insurance. On the whole their plans are marked by indemnity features, certain exclusions, non-coverage of pre-existing diseases and provisions for termination of the contract, which are not infrequently applied.

84. Municipal and co-operative plans are not operative in this Province to our knowledge. Company and union operated plans are dealt with elsewhere in the brief in our comments on Term (h).

85. Industrial Health Services. The practicing physician has an important function in any area where full-time or part-time Industrial Health Services are available. In some instances, the physician works in facilities provided on the premises by the employer. In others, the employees are first seen by a full-time nurse at the place of work and then referred to the physician's office. Nearly all preplacement and other health procedures are carried on in the physician's office.

86. Where full-time physicians are employed by industry, physicians in practice continue with an important role. Medical or surgical conditions found at health examinations are referred to the

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1 employee's own physician for further investigation,
2 consultation with a specialist, or therapy. If
3 therapy is to be carried on while the employee
4 remains at work, the family physician approves this
5 in collaboration with the occupational health
6 physician or nurse. Employees sustaining injuries
7 at work are given emergency care and referred to the
8 physician of their choice for continuing care as
9 Workmen's Compensation Board cases. Established
10 Industrial Health Services assist the family
11 physician in every possibly way without interfering
12 with his practice.

13 87. However, at least one large industrial
14 employer in Nova Scotia has injured employees treated
15 in its own emergency hospital by physicians on
16 salary from the company.

17 88. The follow-up care of these cases is by
18 these physicians even though some of the more
19 seriously injured may have to be transferred to one
20 of the local general hospitals where the patient
21 could have the choice of his personal physician.

22 89. Out-patient follow-up care of these patients
23 is at the company hospital although again they
24 readily could be cared for by their own family
25 physician or a surgical consultant designated by
26 them, with payment from the Compensation Board.

27 90. In both instances, freedom of choice of
28 physician is denied.
29
30

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RELATIONSHIP OF PRIVATE PRACTICE TO HEALTH SERVICES
PROVIDED BY VOLUNTARY AGENCIES.

91. The practicing physician co-operates and frequently actively participates with voluntary agencies interested in providing health services. The co-operation takes several forms, for example, the private practitioner usually is active on the medical advisory committee to Boards of Directors of voluntary agencies, helping to set their policies. The private practitioner plays a large part in detecting suitable cases for referral to voluntary agencies for disease prevention and treatment. Disease prevention by private practitioners complements the programs of voluntary and governmental agencies. In the field of prevention and to a lesser extent in diagnosis and treatment, there is a tendency for voluntary health organizations to engage medical practitioners to carry out their programs, the private practice aspect of medical care being set aside during the time of employment of the doctor. Examples are, the employment of physicians for immunization programs and employment of consultants to travel about the Province diagnosing illness and advising treatment and rehabilitation measures for patients whose illness lies within the sphere of interest of the agency. Such co-operation efforts usually involve financial sacrifices on the part of the practitioner of medicine.

92. A physician often enlists the assistance of

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1 para-medical personnel employed by voluntary
2 agencies for treatment. An example is the
3 prescribing of physiotherapeutic treatment to be
4 carried out by mobile physiotherapy units. In Nova
5 Scotia in the field of rehabilitation, the
6 developments have been particularly significant,
7 inasmuch as physicians have been very active in
8 directing the efforts of the Nova Scotia
9 Rehabilitation Council, a federation of twenty-three
10 voluntary and six governmental agencies interested
11 in their field. The Rehabilitation Council in turn
12 employs physicians to assist in carrying out its
13 program. We cite this as a good example of co-
14 operative effort (Appendix XVI).

15 93 These services by voluntary agencies to the
16 public, assistance to the practicing physician, in
17 supporting education and research, and in health
18 education, are recognized, but there are certain
19 features which require comment as well. The
20 multiplicity of such agencies gives rise to some
21 concern. We feel that there is some overlapping and
22 that a great many groups with very similar goals
23 maintain separate organizations. Increased cost of
24 administration, loss of efficiency and especially
25 a tremendous expenditure of time and energy by public
26 spirited citizens who support their programs and
27 financial campaigns and by physicians are evident.
28 There is some question also in our minds whether
29 some of the efforts at public education about health
30 and disease may have certain harmful effect. Great



care must be exercised in this important field of health education.

94. Most of the voluntary agencies serve a useful purpose. Some have pioneered in a field and the demonstration of the effectiveness of their program has led to the acceptance as an integral part of the public health service financed by government. Those which continue indefinitely to depend upon public charity, should have their programs critically appraised at periodic intervals.

95. Governmental Agencies. Government at the federal, provincial and municipal levels has accepted considerable responsibility for the actual provision of personal health services. Doctors of medicine provide services either on salary, sessional indemnity or on fee for service.

HEALTH SERVICES ADMINISTERED AND FINANCED BY THE
FEDERAL GOVERNMENT.

96. We do not propose an exhaustive analysis of Federal Health Services, but we will comment on those elements of the services which we encounter in this Province. The Medical Society of Nova Scotia recognizes the administration and financing of such services as necessary and desirable.

97. Indian Health Services. The Department of Indian Affairs looks after 3,300 Indians in Nova Scotia. It appoints physicians in various districts to provide services to the Indians and to dispense simple

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1 drugs. There is an appointed Regional Supervisor,
2 who is resident in Sydney. Most of the doctors are
3 paid on a fee-for-service basis, which is based on a
4 schedule of fees much below the official schedule of
5 the Medical Society of Nova Scotia. Some doctors are
6 subject to a maximum financial return in any one
7 year, no matter what medical services may be provided.
8 The result is that the Department of Indian Affairs
9 receives much of its medical services at very low
10 cost. Paper work is cumbersome and complicated.
11 Bills must be rendered in triplicate and checked three
12 or four times before payment. Payments are delayed
13 as long as six months, and money is paid out without
14 definition of what it covers. The administration
15 of services to Indians is complicated by the fact
16 that both the Department of Citizenship and
17 Immigration and the Department of National Health
18 and Welfare are involved. No clear statement of
19 areas of responsibility or eligibility of Indian
20 patients for treatment at the public expense has been
21 made. Accounts for medical services are frequently
22 rejected by the statement that the Indian patient
23 is ineligible. We support the representations which
24 have been made by the Canadian Medical Association
25 to the effect that (a) eligible Indian patients be
26 clearly identified (b) Indian patients should be
27 offered free choice of doctor and (c) physicians
28 should be remunerated on the basis of their
29 provincial fee schedule.
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98. Department of Veterans' Affairs. Treatment

services under the auspices of the Department of Veterans' Affairs and the relationships of the profession with the Department are satisfactory. The personnel of the Royal Canadian Mounted Police also come under this Department. Under the doctor-of-choice plan physicians are remunerated at 90% of the provincial fee schedule for the care of entitled veterans.

99. Sick Mariners Service. On the payment of the required fee per year by the owners of small in-shore fishing boats, and a larger fee according to tonnage by the owners of larger vessels, a sick mariner is entitled to comprehensive care for sickness or injury in the course of his duties. He secures treatment by presenting an Application for Treatment Form signed by the captain of his ship and endorsed by the Customs Officer of the port. The Port Physician, where one is appointed, renders the service. Office calls, minor surgery and dressings are paid for out of the Port Physician's annual stipend or salary. Any surgical procedure costing over \$50.00 on the Department of Veterans' Affairs scale of fees, is billed to the Sick Mariners Service. We recommend that entitled sick mariners be afforded wider choice of doctor than the Port Physician system allows.

100. Medical Services in Federal Penitentiaries. There is one such institution at Springhill, Nova Scotia. Treatment is rendered as required by private practitioners reimbursed according to the schedule

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Department of Veterans' Affairs scale of fees, is
billed to the Sick Mariners Service. We recommend
that entitled sick mariners be afforded wider choice
of doctor than the Port Physician system allows.

is one such institution at Springfield, Nova Scotia.
Treatment is rendered as required by private
practitioners reimbursed according to the schedule



of fees of the Nova Scotia Medical Society.

101. We are aware that a Royal Commission on Federal Government Administration is considering these Federal Health Services and it is possible that the Royal Commission on Health Services may derive useful information.

FEDERAL SERVICES FINANCED BUT NOT ADMINISTERED BY THE FEDERAL GOVERNMENT.

102. National Health Grants. In 1961-62 there are nine health grants from which Nova Scotia benefits (see Appendix XII). These grants are administered by a physician in the Department of Public Health, who is the Director of Health Grants.

103. Inaugurated in 1948, these grants have been directed to the development of such projects as the Nova Scotia Tumor Clinic, The Nova Scotia Rehabilitation Centre and mental health clinics. They have assisted in tuberculosis control and venereal disease control. Training of medical and para-medical personnel has been available as well as financial assistance for medical research in the area of interest of several of the grants.

104. Initially funds from health grants were directed to the purchase of technical equipment for hospitals such as equipment for X-ray, laboratory and case rooms. With the advent of hospital insurance in Nova Scotia as of January 1st, 1959, this became a responsibility for hospitals. As of September 1st, 1961, the training of hospital employees became a responsibility of hospitals. However, funds continue

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1 to be available in the grants for training of
2 medical and para-medical personnel who are not
3 classified as employees of hospitals.

4 105. The administration of these grants with a
5 view to directing them to their most useful purpose
6 in Nova Scotia is rather involved, requiring local
7 consultation followed by discussion with the federal
8 authorities on projects initiated in the Province.
9 It is to be noted that seventy-five per cent of the
10 funds available may be employed for continuing
11 projects, but twenty-five per cent of such funds
12 must be directed to new projects in any one year.

13 106. The Medical Society of Nova Scotia, through
14 representation on the Medical Advisory Committees
15 for these grants, has had liaison with the Department
16 of Health in a consultative and advisory capacity
17 since its inauguration. We are fully aware of the
18 real contribution which is being made and equally
19 conscious that the extension of the principle of
20 grants-in-aid would be advantageous. We endorse the
21 principle of government participation, with the
22 objective of stimulating local interest and local
23 participation leading to improved health services.

24 107. The Federal Civil Service Health Insurance Plan.

25 In 1960 the Federal Government entered the field of
26 medical services insurance by agreeing to participate
27 financially in the provision of medical services and
28 certain extended health benefits. Those eligible
29 for enrolment are the Federal Civil Servants and the
30 dependants of Armed Services personnel and Royal

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1 Canadian Mounted Police.

2 108. Prior to the advent of this plan, in Nova
3 Scotia Maritime Medical Care Incorporated provided
4 comprehensive medical care to 42,046 in these three
5 groups (June, 1960). Maritime Medical Care
6 Incorporated provides a comprehensive service plan
7 in which the first dollar paid in premium is applied
8 to medical service. The Federal Plan is, in effect,
9 an indemnity arrangement with a considerable degree
10 of co-insurance. The Federal Plan provides that 50%
11 of the premium will be paid by the government and
12 the the employees will pay the remainder. The
13 personal contribution to the premium from those who
14 participate in the plan is deducted from pay.

15 109. Before the introduction of the Federal Plan,
16 the government provided facilities to the members of
17 the Armed Forces for collection of the premiums for
18 their dependents enrolled in Maritime Medical Care.
19 Following introduction of the plan, a ruling was
20 given that no new member of the Armed Services could
21 have such deductions made and further, certain rulings
22 created real difficulties for those who wished to
23 continue with the voluntary prepaid medical plan.
24 The Federal Civil Servants paid their monthly
25 premium through Group Secretaries, who were also
26 employees. Rulings have created real difficulties
27 in the continuation of this co-operative effort.

28 110. In our view, the merit of the present
29 Federal Plan is the participation of government in the
30 role of the employer in the payment of premiums.

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1 This shows the interest of government in assisting
2 to provide medical services insurance for the groups
3 involved. It does not, however, provide ready access
4 to medical services to the extent that the voluntary
5 prepaid service plans do because of the deductible
6 feature. In Nova Scotia, actual experience shows
7 preference for the voluntary plan, for not more than
8 25% of those eligible have changed from the plan
9 provided by Maritime Medical Care Incorporated, but
10 have continued to pay for more comprehensive coverage
11 without the employer contribution.

12 111. Therefore, we feel that current
13 administrative rulings are unnecessarily rigid,
14 imposing handicaps on those who prefer the
15 comprehensive service plan. We strongly recommend
16 that entitled persons for the Federal Civil Service
17 medical insurance be permitted to choose between
18 approved service contracts and indemnity contracts,
19 and that the employer contribution of 50% be payable
20 in either event.

21 HEALTH SERVICES ADMINISTERED AND FINANCED BY
22 PROVINCIAL AND/OR MUNICIPAL GOVERNMENTS.

23 112. Public Health Services. The health services provided
24 by the Department of Public Health in the field of
25 public health and preventive medicine are both
26 extensive and varied. They are key factors in the
27 provision of health services in Nova Scotia.

28 113. In the specific area of preventive medicine,
29 health services are projected through eight health
30 units. Within the Atlantic Health Unit, the City of

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1 Halifax has its own Department of Public Health
2 which is administered by a Commissioner of Health
3 who is a Doctor Of Medicine. He reports to City
4 Council and to the Director of the Atlantic Health
5 Unit. Each of the eight regional Health Units has a
6 Director and a staff of qualified public health
7 nurses and other personnel.

8 114. The Director of each Health Unit is a
9 doctor who has had post-graduate training in public
10 health administration and preventive medicine. Each
11 Director has been in clinical practice before taking
12 his post-graduate training and because of this is
13 regarded as a confrere in the clinical field and a
14 consultant with special knowledge in preventive
15 medicine and public health administration. Since the
16 public health of the community is primarily dependent
17 on the health of the individuals in that community,
18 the practicing physician works closely with the
19 Health Unit Director in developing his plans. The
20 physician is aware of the preventive aspects of
21 medicine and in his daily practice applies its
22 concepts. Thus, for example, in the fields of
23 immunization, tuberculosis control and maternal and
24 child health, the Director depends on and receives
25 the co-operation of the practising physician. The
26 practising physician, on the other hand, regards the
27 Health Unit Director as a consultant and feels free
28 to call on his services at any time. In effect,
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1 ancillary to the actual practice of medicine. The
2 public health nurse is a most important factor in
3 community health. While not entering the area of
4 actual clinical nursing of the patient, she has
5 knowledge of the families in her area and works in
6 association with the family physician in many aspects
7 of preventive medicine having to do with the
8 individual.

9 115. The Department of Public Health is also
10 active and responsible in the field of mental health
11 services, in tuberculosis control through preventive
12 programs and sanatorium treatment and follow-up
13 services including the provision of tuberculostatic
14 preparations. In the program for cancer control it
15 also has a very active participation. The
16 provincial laboratories provide services in
17 bacteriology, virology and pathology to which the
18 physician has access. Prior to and since the advent
19 of insured hospitalization there has been a program
20 directed to decentralization of such services with
21 the ultimate objective of having them available to
22 the local hospitals, thus making these essential
23 services more readily available to the physician.

24 116. Another important service rendered by the
25 Department of Public Health relates to the
26 provision of vaccines, sera and other biological
27 products used in the prevention of disease. These
28 are available without charge to physicians for use
29 in their practices. Tuberculostatic drugs and
30 insulin are also available under controlled conditions.

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1 117. The Medical Society of Nova Scotia
2 recognizes the vital importance of these programs
3 and the very real contribution which they make to
4 individual and community health. The services have
5 developed to their present degree as a result of a
6 mutual approach by government, medicine and
7 community to the problems of public health. Having
8 every regard for the importance of these services,
9 they are supportive to the clinical services provided
10 by the physician to the patient. Excluding the City
11 of Halifax, which, as previously mentioned, has its
12 own Department of Health, each of the counties,
13 municipalities, towns and cities appoints a
14 practising physician as Medical Officer of Health.
15 This physician is responsible for the public health
16 in his area and may have other responsibilities
17 inherent in his appointment. He reports to his local
18 council and Health Unit Director. The development
19 of the Health Units has resulted in bilateral
20 benefits resulting in improved community health.

21 118. Mental Health Services. Of all the services
22 administered and financed by provincial and municipal
23 governments, the mental health services are senior
24 in respect to time, very important in terms of
25 incidence, and most urgent in respect to needed
26 improvement. It would be possible to portray our
27 services for psychiatrically and emotionally disturbed
28 patients as antiquated, limited in scope, of low
29 quality, and inadequately financed. All of these
30 observations would be true, but they are equally



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1 applicable to the mental health services in other
2 jurisdictions and they could barely give credit to
3 the slowly developing plans for improvement.

4 119. In Nova Scotia the mental health services
5 publicly provided are administered by a Division of
6 Mental Health and may be summarized as follows:-

7 1. The Community mental health centres,
8 including the Halifax Mental Health Clinic for
9 Childred.

10 2. Hospital services for the mentally
11 ill.

12 3. A very small rehabilitation program,
13 including the pilot project of boarding out mentally
14 ill patients.

15 4. An active training program for workers
16 in the mental health field.

17 5. A modest research program.

18 It should be stated that most of the improvements
19 instituted or contemplated were originally initiated
20 under the Mental Health Grant of the National Health
21 Grants program. This grant is now more than expended
22 in Nova Scotia, and the provincial budget has risen
23 rapidly to over \$4,000,000 during the past fiscal
24 year. Some comment will be made on each of these
25 services.

26 120. First, Community Mental Health Centres have
27 been established in seven of the contemplated ten
28 areas of the Province to provide consultative and
29 treatment services in psychiatry at the regional
30 level. Most of these have some association with the

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been established in view of the contemplated ten areas of the Province to provide consecutive and treatment services in psychiatry at the regional level. Most of these have some association with the



community hospital and hospitalize a few patients. This pattern has particularly developed in the Antigonish area where a psychiatric unit of ten beds is currently being provided at St. Martha's Hospital. These clinics are locally administered but financed to the extent of about 90% from provincial and federal funds. These recently established units are providing good service within their acknowledged limitations, but the duties performed by the staff in these clinics leads one to question their ability to meet the very great demands put on the small staff. There is a great need to strengthen these clinics by more qualified personnel and by more and better local facilities for active treatment. All of these clinics see some children and work with local child caring agencies. However, the only special facility for children in the Province is the Halifax Mental Health Clinic for Children, jointly administered by the City of Halifax, the Province and the University. This provides an active diagnostic and treatment service, but the waiting list for treatment now extends to one year. There is also an attempt to give some special help to the problems of mental retardation; but the demands are great, the funds are small, and in truth, there is no psychiatrist in the Province who has adequate training in this field. Apart from this clinic, there are no special efforts in any of the communities to deal with the problem of mental retardation.

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121. Hospital Services for the Mentally Ill. Striking changes have been made at the main hospital in the Province, the Nova Scotia Hospital, Dartmouth, an institution of 500 beds with a patient load which frequently exceeds this figure. The medical staff consists of 21 physicians of whom 13 have had some post-graduate training in psychiatry. The staff also includes 4 psychologists, 9 social workers, 1 occupational therapist, 84 registered nurses, 237 attendants. The institution is regarded as an active treatment mental hospital, and admission and discharges are approximately 1,300 a year. One of the very satisfying things in the mental health field in this Province has been the marked improvement in care in the Nova Scotia Hospital during the past ten years. This is largely due to the building up of staff; and this hospital is probably staffed as well as almost any mental hospital on the continent, as far as physicians, psychologists, social workers are concerned. However, it is woefully inadequate in occupational therapists and other people working the rehabilitative field. There is need for a very considerable extension of staff and facilities to deal adequately with the problems presented. A unique and unpraiseworthy feature of the approach of Nova Scotia to institutional care of the mentally ill is the presence of eight municipal hospitals, varying in size from 60 to 500 beds, with a total capacity of 2,100 patients. It should be noted that the Government



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1 has stated as its objective in medical care for these
2 institutions the provision of one psychiatric
3 examination a year with care being provided by
4 general practitioners. It is the opinion of this
5 Society that such care is not adequate for these
6 2,100 patients; and we believe it fair to say that
7 these institutions provide little more than custodial
8 care and in some instances this sinks to a low level.
9 There are no occupational therapists, social workers,
10 or any other personnel to apply modern techniques at
11 remotivation and rehabilitative therapy. Despite
12 the fact that these institutions are disbursed,
13 their location, which bears no relationship to
14 existing medical facilities, is not conducive to
15 adequate medical supervision. The lack of
16 psychiatric care is intolerable and the indiscriminate
17 mixing of senile patients, mentally retarded children
18 and adults as well as disturbed psychotics, violates
19 all modern principles. It is astonishing that any
20 patient ever improves to the point where he may be
21 discharged. This certainly is one of the areas that
22 most deserves condemnation in Nova Scotia. The Nova
23 Scotia Training School is a 160 bed institution
24 operated by the Department of Public Welfare for
25 children who are diagnosed mentally defective. There
26 is a psychiatric consultant but no psychiatrist on
27 the staff, and it would be our opinion that there is
28 need for much more psychiatric help in the care
29 offered by this institution.

30 122. Rehabilitation in Mental Illness. As noted, there



has stated as its objective in medical care for these institutions the provision of one psychiatric examination a year with care being provided by general practitioners. It is the opinion of this Society that such care is not adequate for these 2,100 patients; and we believe it fair to say that these institutions provide little more than custodial care. There are no occupational therapists, social workers, or other personnel to apply modern psychiatric methods of rehabilitation and rehabilitative therapy. Despite the fact that these institutions are disbursed, their location, which bears no relationship to existing medical facilities, is not conducive to adequate medical supervision. The lack of psychiatric care is intolerable and the indiscriminate mixing of children, adults, and disturbed psychotics, violates all modern principles. It is astonishing that any patient ever improves to the point where he may be discharged. This certainly is one of the areas that most deserves condemnation in Nova Scotia. The Nova Scotia Training School is a 160 bed institution operated by the Department of Public Welfare for children who are diagnosed mentally defective. There is a psychiatric consultant but no psychiatrist on the staff, and it would be our opinion that there is need for much more psychiatric help in the care offered by this institution.

Rehabilitation in Mental Illness. As noted, there

1 is very little rehabilitation in an organized way
2 in this Province. Each one of the clinics does a
3 certain amount of rehabilitation of patients in
4 their area. There is a small boarding out program
5 as mentioned, and there is a small special project
6 in rehabilitation in one of the regions. However,
7 this is quite inadequate to meet the demands; and
8 the sad fact is that most of the patients discharged
9 from the Nova Scotia Hospital or the Victoria
10 General Hospital are returned to their homes, without
11 even provision being made for necessary drugs. The
12 result is that many such patients return to hospital
13 not having been able to afford their drugs. This
14 also represents one the the serious areas of need in
15 the Province.

16 123. Training of Workers in the Mental Health Field.

17 The Province for a number of years has offered an
18 active program of bursaries for training in the field
19 of psychiatry, social work, psychology and related
20 specialties. Most of this has been done through the
21 Departments of Psychiatry and Psychology at
22 Dalhousie University. This program has resulted in
23 a very marked bettering of the staff situation in
24 the Province and should be continued and reinforced.

25 124. A Modest Research Program. This largely consists of

26 the support of the "Sterling County"* studies in the
27 Digby area. This has been completed and research is
28 now not active in the Province. A few research
29 projects are being carried out under federal grants
30 in the University, but both in the provincial and

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1 university spheres there is need for much
2 stimulation.

3 125. Facilities Not Operated Directly by the Province.
4 (Psychiatric Units)

5 There are two psychiatric units in general hospitals
6 in Halifax, that at the Victoria General Hospital
7 and Camp Hill Hospital (Department of Veterans'
8 Affairs). There are plans now being completed for a
9 unit at the Halifax Infirmary. These units are
10 staffed by University teachers and private
11 practitioners of psychiatry and operate as do the
12 usual clinical facilities of the hospitals concerned.
13 They are moderately well staffed as far as medical
14 personnel is concerned, but the only unit in the
15 Province adequately equipped with psychologists,
16 social workers, occupational therapists, etc. is
17 Camp Hill Hospital. Indeed, in the other units, no
18 occupational therapy is available at present. There
19 is a distinct need for more psychiatric units in
20 general hospitals and a considerable increase in
21 staff in the units currently being operated. In
22 addition, at the Victoria General Hospital there is
23 a large psychiatric out-patient department which
24 sees approximately 1,300 patients a year. This
25 provides out-patient electro-convulsive therapy,
26 group and individual psycho therapy and many of the
27 other modern methods of psychiatric care. However,
28 this out-patient facility needs a very considerable
29 development if the demands of this part of Nova
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Scotia are to be met. There are no day or night

hospital facilities in the Province.



1 126. The foregoing summarizes the present state of
2 psychiatric services in Nova Scotia. As will be
3 noted, none of them can be considered approaching
4 adequacy. Most of them are operating at a minimal
5 staff level and with a minimal budget. All of them
6 have a work load which severely mitigates against
7 quality service. In addition to the government-
8 provided services, there is a fair amount of private
9 psychiatric practice. In the Halifax area there are
10 eight practitioners devoting part of their time to
11 private practice, and this area is moderately well
12 served. Nevertheless, it might be pointed out that
13 almost all of these individuals have an appointment
14 list which extends for at least a month; and it is
15 exceedingly difficult to provide care for emergency
16 patients. Throughout the Province, in each one of
17 the community clinics, the psychiatrist spends a
18 small percentage of his time in private practice but
19 for the most part, such services are not available.
20 When we consider the very large budget for
21 psychiatric care currently being expended and the
22 frequent demands that we hear from patients who wish
23 to provide for their own psychiatric care, it is our
24 opinion that a medical scheme which would include
25 more in the way of private psychiatric care would be
26 eminently desirable.

27 127. The Nova Scotia Division of the Canadian
28 Psychiatric Association has supplied us with the
29 following summary of their recommendations which
30 we endorse and command to the Royal Commission and to



126. The foregoing summarizes the present state of

psychiatric services in Nova Scotia. As will be noted, none of them can be considered approaching adequacy. Most of them are operating at a minimal staff level and with a minimal budget. All of them have a work load which severely mitigates against quality service. In addition to the government-provided services, there is a fair amount of private psychiatric practice. In the Halifax area there are eight practitioners devoting part of their time to private practice, and this area is moderately well served. Nevertheless, it might be pointed out that almost all of these individuals have an appointment list which extends for at least a month; and it is exceedingly difficult to provide care for emergency patients. Throughout the Province, in each one of the community clinics, the psychiatrist spends a small percentage of his time in private practice but for the most part, such services are not available. When we consider the very large budget for psychiatric care currently being expended and the frequent demands that we hear from patients who wish to provide for their own psychiatric care, it is our opinion that a medical scheme which would include more in the way of private psychiatric care would be desirable.

The Nova Scotia Division of the Canadian Psychiatric Association has supplied us with the following summary of their recommendations which we endorse and commend to the Royal Commission and to



1 the Government of Nova Scotia for implementation.

2 128. We recommend:-

3 1. That problems in the mental health field
4 be recognized and acknowledged as a major health
5 problem.

6 2. Qualified personnel is the first
7 requirement. The aid of the Mental Health Grants
8 has been instrumental in such progress as has been
9 made. Amplification to meet the pressing needs of
10 mental health is recommended.

11 3. In addition, the centres capable of
12 providing the essential training should be aided in
13 expanding their facilities. Medical education
14 recognizes that teaching in the psychiatric field is
15 essential for all doctors. To provide a satisfactory
16 career attractive to young men in the mental health
17 field, we recommend that psychiatric patients be
18 treated in all respect as other sick people. This
19 would include psychiatric hospitalization under the
20 federal-provincial hospital scheme.

21 4. Early, high quality and continuous treatment
22 can best be provided with medical personnel
23 remunerated on a fee-for-service basis.

24 5. We recommend that patients be covered by a
25 prepaid medical insurance plan.

26 6. We recommend the expansion of out-patient
27 facilities to provide care by the psychiatric team
28 (psychiatrists, psychologists, social workers) to
29 supply high quality service; and this would include
30 provision for necessary drugs.



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5. We recommend that patients be covered by a prepaid medical insurance plan.

6. We recommend the expansion of out-patient facilities to provide care by the psychiatric team (psychiatrists, psychologists, social workers) to supply high quality service; and this would include provision for necessary drugs.



7. We recommend the expansion of in-patient facilities especially in general hospitals and in small local units close to general hospitals.

8. We recommend that the reform of county hospitals be accelerated and that they be abandoned unless they can provide high standards in keeping with modern psychiatric principles for the care of the mentally ill.

9. We recommend that special studies be set up to the end of providing the best possible care in geriatric and forensic psychiatry, alcoholism, and other special fields.

10. We recommend the strengthening of facilities for child psychiatry.

11. We recommend increased facilities for the prevention and treatment of mental retardation.

12. We strongly point out that knowledge is meagre in nearly all of these areas and recommend the support of psychiatric research programs as being of fundamental importance.

129. Tuberculosis Control. The program for tuberculosis control in Nova Scotia is directed by the Administrator of Tuberculosis Control Services, who is a physician and is also Medical Superintendent of the Nova Scotia Sanatorium (300 beds).

130. The Health Unit Director in turn has the co-operation of the practising physicians in his area in case finding and reporting new patients with respect to the actual disease, tuberculosis. The Health Unit Director acts as consultant and holds

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clinics, notices of which are sent to physicians and ex-patients in advance.

131. Public health nurses co-operate with the family physician in assessing contacts of known tuberculosis, visits to patients who are receiving home treatment and follow-up of the patient and the contacts.

132. Admission of patients to the Nova Scotia Sanatorium (Kentville), Point Edward Hospital (Sydney - 184 beds) and the Halifax Health Centre (Halifax - 26 beds), are arranged by the Health Unit Director. There are 45 beds at the Nova Scotia Hospital for mental patients with tuberculosis. Treatment facilities are available to patients without charge.

133. Earlier diagnosis and recent advances in treatment including tuberculostatic preparations and surgery, have led to a great reduction in the beds required for this disease. It is to be noted that in the 1930's, based on the reasoning that tuberculosis is a communicable disease and could be brought under control, the Government of Nova Scotia adopted the policy of building beds as tuberculosis units attached to general hospitals. This policy forecast that, as the demand for treatment became less (because of control measures), such beds could be included for general hospital use. All tuberculosis unit beds had been so transferred by 1960.

134. In general, once an individual has become



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1 infected with tubercle bacilli, there is a risk of
2 him developing the disease in some system of his
3 body sometime during his life. Because of this,
4 tuberculin testing is being more extensively
5 employed, since a positive reaction indicates
6 infection with tubercle bacilli. The number of
7 individuals with positive reaction is becoming
8 progressively less, particularly in the younger age
9 groups. The identification and management of the
10 positive reactors is an integral part of a modern
11 program and should be extended to cover the whole
12 population at stated intervals. Tuberculin testing
13 is a routine procedure in the majority of nursing
14 schools, in the Medical School and Dental School.
15 X-ray of positive reactors is mandatory and is an
16 insured service under the Nova Scotia Hospital
17 Insurance Plan. B. C. C. vaccine, which decreases
18 the risk of developing disease in negative tuberculin
19 reactors by 80 %, should be more extensively employed
20 in contacts of patients with disease and personnel
21 with the occupational hazard of exposure to
22 tuberculosis infection from known and unknown cases
23 of tuberculosis.

135. Reactivation of disease in patients known
24 to have tuberculosis, particularly the pulmonary
25 form, is a constant hazard. The ex-patients require
26 regular re-check examinations, including examination
27 of pulmonary secretions to determine the bacillary
28 status, i.e. whether tubercle bacilli are present
29 or not.
30



infected with tubercle bacilli, there is a risk of him developing the disease in some system of his body sometime during his life. Because of this, tuberculin testing is being more extensively employed, since a positive reaction indicates infection with tubercle bacilli. The number of individuals with positive reaction is becoming progressively less, particularly in the younger age groups. The identification and management of the positive reactors is an integral part of a modern program and should be extended to cover the whole population at stated intervals. Tuberculin testing is a routine procedure in the majority of nursing schools, in the Medical School and Dental School. X-ray of positive reactors is mandatory and is an insured service under the Nova Scotia Hospital Insurance Plan. B. C. G. vaccine, which decreases the risk of developing disease in negative tuberculin reactors by 80%, should be more extensively employed in contacts of patients with disease and personnel with the occupational hazard of exposure to tuberculosis infection from known and unknown cases of tuberculosis.

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- 1 136. Because of the marked decrease in
2 tuberculosis mortality and because of earlier
3 diagnosis and more efficient treatment, there is a
4 general feeling that tuberculosis does not require
5 the attention it merits.
- 6 137. We are still in a dangerous position and
7 each facet of the effort to control the disease on
8 the part of government, physicians and voluntary
9 agencies must be kept active, with changes of
10 emphasis in the basic program as progress is made.
- 11 138. Cancer Control. The care of the patient with cancer
12 in Nova Scotia may be considered in two categories:
13 (1) those cared for through the Nova Scotia Tumor
14 Clinic and (2) those cared for by private physicians
15 in hospitals throughout Nova Scotia.
- 16 139. Information concerning the incidence, type
17 of cancer, treatment and follow-up is available only
18 from those cases treated through the Nova Scotia
19 Tumor Clinic. We have no true picture of the
20 incidence, treatment or quality of follow-up on the
21 remaining cases. For a long time we have realized
22 the necessity for a Central Tumor Registry where
23 information on all forms of cancer could be recorded.
24 The Cancer Committee of the Nova Scotia Medical
25 Society has recommended to the Department of Health
26 that a registry be set up.
- 27 140. The Nova Scotia Tumor Clinic provides
28 physicians' services without charge, regardless of
29 financial state of the patient. The Medical Staff
30 has to date contributed its services without

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1 remuneration but the volume of work has been so
2 burdensome that payment for services should be
3 considered.

4 141. New Chemo-therapeutic drugs and other means
5 of treatment in cancer cases are being introduced
6 and studied in all centres of the world. Some of
7 these are found to be useful. Two of our needs in
8 this centre are basic research and a consultant for
9 chemo-therapy. The Nova Scotia Tumor Clinic has
10 already made strong recommendations along these lines.
11 This is essential if the cancer patient is to receive
12 the best from our treatment centre.

13 142. It has been established that a single tumor
14 clinic is sufficient for a province the size of Nova
15 Scotia. This means, then, that most patients with
16 cancer will be referred to the Nova Scotia Tumor
17 Clinic, and probably return for follow-up. There
18 must be some means to accommodate such persons
19 without having them admitted to the hospital and
20 thus taking up active treatment beds. This is one
21 reason for the development of a hostel for cancer
22 patients situated in the proximity of the Tumor
23 Clinic. The treatment of malignant conditions by
24 radiation therapy is without charge to all residents
25 of the Province through the Hospital Insurance Plan.
26 A course of treatment may last for four to six weeks.
27 It is to be noted that necessary drugs are provided
28 without charge only if the patient is hospitalized.
29 This may mean hospitalization for the duration of
30 treatment even though many would be better off as

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1 out-patients. These are additional reasons for the
2 recommendation that a hostel for cancer patients be
3 made available. It is to be noted that the cost of
4 transportation is provided for needy patients to
5 the Tumor Clinic for treatment of malignant
6 conditions.

7 143. New drugs and hormones in the treatment of
8 cancer frequently are expensive and beyond many
9 patients' ability to purchase. Narcotic drugs are
10 usually required for terminal cases. It is suggested
11 that arrangements be developed so the such patients
12 are provided with drugs on a basis similar to that
13 at present applicable to the diabetic patient in
14 Nova Scotia. Such assistance would not only be
15 advantageous to the patient with cancer, but would
16 assist toward releasing active treatment beds for
17 their primary purpose.

18 144. No report on cancer control would be
19 complete without mentioning the good work of the
20 Canadian Cancer Society. The Society was set up with
21 three objectives in mind, (1) research, (2) education,
22 (3) welfare. The budget of the Nova Scotia Branch
23 is necessarily small and this appears to have
24 curtailed the welfare work of the Society. Some
25 cancer patients need welfare services at some in the
26 form of drugs and help especially for the care of
27 terminal cases.

28 145. We recommend that:
29 (a) A Central Tumor Registry be developed.
30 (b) Trained personnel in basic research and in



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We recommend that:

- (a) A Central Tumor Registry be developed.
- (b) Trained personnel in basic research and in



the use of chemo-therapeutic agents be appointed to the Nova Scotia Tumor Clinic.

(c) Physicians serving in the Nova Scotia Tumor Clinic be remunerated.

(d) A hostel for cancer patients be developed.

(e) Financial assistance to purchase drugs be provided to patients with cancer.

(f) The cytological research project which is now being conducted in cancer of the cervix be extended. This is under the auspices of the Nova Scotia Medical Society and financed by a national health grant. Already good results have been reported in that unsuspected cancer has been revealed.

146. Alcohol and Drug Addiction. We understand that there is a little drug addiction in Nova Scotia and that present facilities are adequate to detect and manage the few who are involved.

147. Alcoholism. The Nova Scotia Alcoholism Research Commission was authorized by Chapter 2 - Statutes of Nova Scotia - 1939. The Commission is directed to:

- (a) Inquire into the cause of alcoholism;
- (b) Inquire as to ways and means to prevent alcoholism;
- (c) Inquire into methods of treatment designed to rehabilitate persons who are subject to alcoholism;
- (d) Carry on a program of temperance education;
- (e) Disseminate information respect the causes, recognition, prevention and treatment of alcoholism.

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(c) Physicians serving in the Nova Scotia

the use of chemo-therapeutic agents be appointed to



January, 1961, and a final report is now in preparation.

148. The Commission defines alcoholism as follows:-

"Alcoholism is a state of dependence on the use of beverage alcohol resulting in the appearance, in the individual, concerned of harmful effects of a social, mental or physical nature".

149. There are at present no facilities for the treatment of chronic alcoholism. The medical profession is aware of the problem and will be active in the support of a solution relative to the medical aspects.

HEALTH SERVICES FINANCED BUT NOT ADMINISTERED BY PROVINCIAL GOVERNMENTS.

150. Social Assistance Medical Services Programs. This introduces a subject which is very complex from the standpoint of the provision of medical services to recipients of public assistance under the various Acts involved. Appendix IX, is a summary of the legislation dealing with these matters, kindly provided by the Deputy Minister of Welfare at the request of the Society.

151. The Social Assistance Act of Nova Scotia provides for financial aid to certain groups of individuals. This group numbers 22,569 and includes 10,900 persons in receipt of municipal assistance. Adding to this number there are 8,855 who receive assistance in the Old Age Assistance Division, made up as follows:-

Old Age Assistance (65-70 yrs.)	5,395
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1 Old Age Assistance (65-70 yrs.) 5,395

2 Blind Persons Allowance
3 (18-70 yrs.) 786

4 Disabled Persons Allowance
5 (18-70 yrs.) 2,704

6 8,885

7 In total, 31,454 are receiving financial assistance
8 from public funds:-

9 (a) Those receiving prepaid medical
10 services through government payment of premiums

11 Under Social Assistance Act 9,046

12 Blind Persons Allowance 786

13 9,832

14 (b) Individuals in these groups
15 not covered thru payment by
16 Government for premiums for
17 prepaid medical care 21,622

18 Total 31,454

152. The coverage of group (a) was initiated thru
19 an approach (1950) by the Government to the Medical
20 Society of Nova Scotia. An agreement (Appendix IX)
21 resulted whereby prepaid medical services to the
22 "Welfare Group" by members of the Society provided
23 medical services with Maritime Medical Care
24 Incorporated as its agent. The Department of Public
25 Welfare pays to Maritime Medical Care Incorporated
26 \$1.30 per month per beneficiary and the Maritime
27 Medical Care is billed by the physician for the
28 medical services rendered. The Medical Society of
29 Nova Scotia or the Department of Public Welfare may
30 initiate discussions on the agreement at any time
and usually do so once a year. The plan has been in

Old Age Assistance (65-70 yrs) 5,395
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from public funds:-

(a) Those receiving prepaid medical services through Government payment of premiums

Blind Persons Allowance 86

(b) Individuals in these groups not covered thru payment by Government for premiums for prepaid medical care 21,632

Total 21,718

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continuous operation since 1950 and it is to be noted that services now provided are more extensive than at the beginning. It is also to be noted that needy Old Age Pensioners were included for medical services until 1952 when the Federal Government took over the responsibility for full payment of these pensions.

153. We wish to emphasize that the principle underlying this agreement between the Government and the Medical Society of Nova Scotia is an example of participation by government and by the practising physicians in providing prepaid medical services to two groups with low income. The subsidization by the practising physician amounts to approximately 50% for all services rendered, the range of subsidization varying with the particular type of service provided. The physician does not restrict his services to the terms of the agreement and the patient always receives the medical or surgical care required. The requirements are met in terms of quality medical care but not in terms of cost. We submit that this principle of participation in extending medical services to other groups receiving social assistance and also to those whose income is below a stated figure, is sound.

154. We recommend that all persons receiving assistance from public funds should have available to them prepaid medical services. This would be provided by participation of government and the medical profession.

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We recommend that all persons receiving to them prepaid medical services. This would be provided by participation of government and the



155. Medical Services for the Chronically Ill, Including Rehabilitation.

The medical services in this field of medicine, particularly for the chronically ill, have been inadequate. The need is pressing for hospital beds for the chronically ill and for long-term illness. Assistance to certain fields of illness, for example rehabilitation in acute disabilities, arthritis and neurological illnesses, has been provided through federal-provincial health grants. These are limited in their application, since they can only be employed for specific purposes. There is an urgent need for long-term care units attached to the general hospitals, for convalescent hospitals and for hospitals for the care of those with incurable chronic illness. The lack of hospitals for the chronically ill results in misuse of beds designated for convalescent cases and of beds for active treatment. Many chronically ill individuals eventually find themselves in totally inappropriate surroundings, for example in surroundings designed only for custodial care. The provision of medical services for the chronically ill presents many special problems. The lack of special facilities may result in actual neglect in the care of this type of illness. There is often a problem in relation to the cost of necessary long-term drug treatment and a problem in the recognition on the part of the patient and the doctor of the need for periodic re-assessment of his diseased state. This will be

The medical services in this field of medicine, particularly for the chronically ill, have been inadequate. The need is pressing for hospital beds for the chronically ill and for long-term illness. Assistance to certain fields of illness, for example rehabilitation in acute disabilities, arthritis and neurological illnesses, has been provided through specific hospital units. However, the need is pressing in their application, since they can only be employed for specific purposes. There is an urgent need for long-term care units attached to the general hospitals, for convalescent hospitals and for hospitals for the care of those with incurable chronic illness. The lack of hospitals for the chronically ill results in misuse of beds designated for convalescent cases and of beds for active treatment. Many chronically ill individuals are discharged from hospital care and are unable to obtain necessary medical care. The provision of medical services for the chronically ill presents many social problems. The lack of special facilities may result in actual neglect in the care of this type of illness. There is often a problem in relation to the cost of necessary long-term drug treatment and a problem in the recognition on the part of the patient and the doctor of the need for periodic re-assessment of his diseased state. This will be

1 an increasing problem with the aging of our
2 population. The location of such chronic and
3 convalescent facilities close to active treatment
4 hospitals is very important for the adequate care
5 of these patients.

6 156. An important element in the treatment of
7 patients with chronic disabilities is rehabilitation.

8 157. To provide for more effective rehabilitative
9 services in Nova Scotia, we endorse the following
10 recommendations:-

11 (a). In order to have effective medical
12 rehabilitation in Nova Scotia, there must be more
13 education of the medical profession so that existing
14 facilities and those that will become available in the
15 future will be used efficiently. We feel that the
16 medical students must be given a good grounding in
17 these concepts and methods and the University Medical
18 School is the best place to start this education
19 process. Each regional hospital which is to be
20 equipped with a physiotherapy or occupational therapy
21 department should have on its staff at least one
22 doctor who has some degree of additional training
23 in the use of these treatment methods and who will
24 be delegated by the medical staff to take special
25 interest in and responsibility for proper functioning
26 of these departments. University sponsored refresher
27 courses may be the answer to the provision of this
28 type of physician, providing proper incentives are
29 available.

30 (b) It will be necessary to expand the physical

an increasing problem with the aging of our population. The location of such chronic and convalescent facilities close to active treatment hospitals is very important for the adequate care of these patients.

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1 medicine and rehabilitation facilities in the main
2 referral hospitals as well as establish physiotherapy
3 and occupational therapy departments in all regional
4 and some other local hospitals. This implies, of
5 course, a considerable expansion in the number of
6 available personnel. With regard to the expansion
7 of personnel, the following recommendations are
8 made:-

9 1. Establishment of a school of physio-
10 therapy and occupational therapy at Dalhousie
11 University as soon as possible.

12 2. A recruitment campaign to interest
13 high school students in the various para-medical
14 fields such as medical social work, vocational
15 counselling, physiotherapy, occupational therapy,
16 speech therapy.

17 3. Continuation of the program for
18 provision of bursaries to assist students who wish
19 to take training in these fields. (Appendix XII).

20 4. The establishment of adequate salary
21 scales in these para-medical fields so that Nova
22 Scotia can attract sufficient workers of high
23 calibre.

24 (c) Expansion of the bed capacity and other
25 facilities of the Nova Scotia Rehabilitation Centre,
26 and the establishment of similar centres elsewhere,
27 with special attention to our industrial areas.

28 (d) The expansion of the Brace and Limp Shop
29 facilities in the Province so that appliances of all
30 types can be manufactured locally without undue delay.

medicine and rehabilitation facilities in the main referral hospitals as well as establish physiotherapy and occupational therapy departments in all regional and some other local hospitals. This implies, of course, a considerable expansion in the number of available personnel. With regard to the expansion of personnel, the following recommendations are made:--

1. Establishment of a school of physio-

therapy and occupational therapy at Dalhousie

University as soon as possible.

2. A recruitment campaign to interest

high school students in the various para-medical

fields such as medical social work, vocational

3. Continuation of the program for

provision of bursaries to assist students who wish

to take training in these fields. (Appendix XII).

4. The establishment of adequate salary

scales in these para-medical fields so that Nova

Scotia can attract sufficient workers of high

calibre.

(c) Expansion of the bed capacity and other

facilities of the Nova Scotia Rehabilitation Centre,

and the establishment of similar centres elsewhere,

with special attention to our industrial areas.

(d) The expansion of the Brace and Limb Shop

facilities in the Province so that appliances of all

types can be manufactured locally without undue delay.



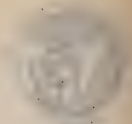
1 It would also be necessary for an efficient Brace
2 and Limp Shop to have the skill, time and space to
3 experiment with, and use effectively, the latest
4 methods and materials for fabrication of prosthetics
5 appliances.

6 (e) We feel that it will be important to set
7 up a transportation system to bring certain types of
8 patients in out-lying areas to the regional hospital
9 clinics and departments. In some instances this
10 would be effective in releasing hospital beds, and
11 in other instances the patient would be able to
12 receive treatment that would otherwise not be
13 available near his home.

14 (f) Where the transportation system is not
15 effective because of the severe disability of the
16 patient or the distances involved, some mobile home
17 services should be available, including physiotherapy,
18 medical social workers and in certain special
19 problems, occupational therapists.

20 (g) Although the services of physical medicine
21 and rehabilitation specialists could not likely be
22 available to all parts of the Province in the near
23 future on the static basis, these consultants should
24 be available to all areas on a travelling consultation
25 basis.

26 (h) There is a great need in the Province for
27 the provision of institutions designated to care for
28 the long-term patient, whether he requires continued
29 active medical care in a rehabilitation hospital, a
30 convalescent hospital, or whether he requires only



It would also be necessary for an efficient space and time shop to have the skill, time and space to methods and materials for fabrication of prosthetics appliances.

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(f) Where the transportation system is not effective because of the severe disability of the patient or the distances involved, some mobile home services should be available, including physiotherapy, medical social workers and in certain special problems, occupational therapists.

(g) Although the services of physical medicine and rehabilitation specialists could not likely be available to all parts of the Province in the near future on the static basis, these consultants should be available to all areas on a travelling consultant basis.

(h) There is a great need in the Province for the provision of institutions designed to care for active medical care in a rehabilitation hospital, a convalescent hospital, or whether he requires only



occasional care in a custodial type of institution. High standards must be maintained in these hospitals so that no opportunities are lost to exploit the possibilities for physical and vocational rehabilitation and it is essential that each has adequate physical medicine and rehabilitation facilities to assist the fullest possible recovery of these patients. Again these physical medicine facilities should be supervised by a physician who is adequately trained in methods and concepts of physical restoration. We are not in a position to make a specific recommendation as to the number of rehabilitation centre, convalescent hospital, and custodial hospital beds necessary, but we are led to believe that this problem has been defined in surveys conducted by the Nova Scotia Hospital Insurance Commission.

(i) We recommend that when the cost of a proper rehabilitation plan for Nova Scotia is being estimated, some consideration be given to the administration and supervisory aspects of the physical medicine and rehabilitation specialist, in addition to the usual direct professional contact between this specialist and the patient he is asked to diagnose and treat.

158. Blood Transfusion Services. Blood transfusions are made available to the people of Nova Scotia almost entirely through the transfusion service organized and administered by the Canadian Red Cross Society. The one exception in this Province is Saint Martha's

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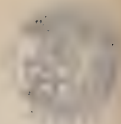
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1 Hospital, Antigonish, which operates its own blood
2 transfusion service.

3 159. The Red Cross program represents a co-
4 operative effort between the volunteer blood donor,
5 the Provincial Division of the Red Cross Society,
6 the National Red Cross Blood Transfusion Service,
7 the Provincial Government, the Hospital Insurance
8 Commission, the administration of all hospitals and
9 the medical profession to ensure that all blood and
10 all blood products are available as needed by the
11 people of this Province in the provision of personal
12 health service and that these are without charge
13 to the patient.

14 160. The volunteer donor is the key figure in
15 the program because he gives his blood without
16 charge. The Provincial Division of the Red Cross
17 Society plays a major role by promoting and
18 organizing the volunteer blood donor clinics. The
19 National Blood Transfusion Service, through its
20 provincial Depot, is the servicing link between the
21 volunteer donor and the hospital. Its function
22 therefore is to procure, transport, properly store,
23 process, test and distribute blood to the hospitals
24 of this Province. The Provincial Government
25 contributes considerably by providing working
26 facilities for the Blood Transfusion Service and by
27 underwriting some of the operational costs. The
28 Hospital Insurance Commission now helps by absorbing
29 the laboratory cross-match charges. Hospital
30 administrations and the medical profession contribute



Hospital, Antigonish, which operates its own blood

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by ensuring that blood and blood products are provided to the patients without charge. The results speak for themselves and few who know the problems elsewhere in the world would disagree that Nova Scotians have been fortunate in having the present facilities and methods operating in this Province during the past 15 years; in addition, it may be added that no one has been able to devise or suggest a more comprehensive or a more efficient program for making blood available to the people.

161. Excellent as the program is, it suffers from the defect of centralization. The provision of additional regional sub-depots in suitable hospitals, with facilities for cross-matching, should bring better and faster service to the patient.

HEALTH SERVICES PROGRAMS ADMINISTERED BY PROVINCIAL
BOARDS BUT NOT FINANCED BY THE PROVINCES.

162. Workmen's Compensation Board. The Workmen's Compensation Board functions under the Workmen's Compensation Act and Regulations. The Act was passed in 1915 and became operative in 1917. In March 1957, Judge A. H. MacKinnon was appointed a Commissioner "to inquire into and make recommendations regarding the Workmen's Compensation Act".

163. All physicians in practice are intimately involved in the provision of medical services to those eligible for Workmen's Compensation and hence the Medical Society of Nova Scotia prepared a brief which presented its views and recommendations. The comprehensive report of the Commission was available

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1 early in 1959. As we believe the Commissioner's
2 report to be a most comprehensive one, reviewing
3 the health services to this group, including its
4 medical aspects, we would refer the Royal Commission
5 to the document for further information.

6 164. The views and recommendations of the Medical
7 Society were incorporated in the recommendations of
8 the Commission. Two of these recommendations we
9 would repeat.

10 1. "Rehabilitation. We feel that it is not
11 enough to care for workmen until simple healing of
12 a damaged part has occurred but rather that every
13 effort should be made to restore him mentally and
14 physically to his place in society as completely and
15 quickly as possible. We believe that the principle
16 of rehabilitation has not been sufficiently applied
17 to give the best results to the disabled patient and
18 that with such rehabilitation services now available
19 in Nova Scotia, they should be utilized to their
20 full extent. Despite the fact that the Act
21 recognizes this in Section 97, we believe that
22 rehabilitation services can be more extensively
23 utilized than they are at the present time".

24 2. "Arbitration & Liaison. In view of the
25 absolute powers vested in the Board in the present
26 Act, to determine the fees to be paid for professional
27 services, we request that a joint conference
28 committee be created. Such a Committee might consist
29 of three members of the Workmen's Compensation Board
30 and three representatives of the Medical Society of

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2. "Arbitration & Liaison". In view of the absolute powers vested in the Board in the present Act, to determine the fees to be paid for professional services, such a Committee might consist of three members of the Workmen's Compensation Board and three representatives of the Medical Society or

Nova Scotia. It is suggested that:-

(a) Such a committee should have statutory recognition.

(b) It should have the power to effect arbitration to disputes between the Board and the members of the medical profession.

(c) It should be directed to meet at regular intervals for the purpose of effectual liaison and discussion of any problems which may arise with either of the parties.

(d) There should be authority for either party to call a meeting of this committee at such times as may be required".

165. As a result of this latter recommendation, our Liaison Committee has been functioning without legal status and has held three meetings during the current year. We would note particularly that under the present conditions the physicians' services include considerable subsidization by the physician of the medical services available under the Workmen's Compensation Act as indicated above. This is one of the matters that is being explored by the Liaison Committee.

THE HOSPITAL AS AN ELEMENT OF MODERN MEDICAL CARE

166. Active Treatment Hospitals. There are 47 civilian active treatment hospitals in Nova Scotia with a total number of 3,563 beds. These hospitals are operated by their individual boards under the Nova Scotia Hospital Insurance Act which is administered by the Nova Scotia Hospital Insurance Commission.

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The Act provides standard ward care, without charge, to entitled residents of Nova Scotia who are admitted to a hospital because of "medical necessity". In most cases this would be for treatment of specific conditions, but in some cases it would be "medically necessary" for certain patients to be admitted primarily for diagnostic services.

167. The hospital's fundamental purpose is to care for the sick and the following departments are directly involved:

1. Administration - In this department there appears to be a definite shortage of medical social workers and medical record librarians.
2. Medical Services - These are provided by the medical staff which organized so that, in so far as possible, it will fulfil the requirements of the Canadian Council on Hospital Accreditation. The latter will result in the patients receiving a high standard of care but require the formation and active participation of a number of committees. These include:

(a) Joint Conference Committee - to meet with a similar committee from the Administration to deal with problems of mutual concern.

(b) Tissue Committee - to correlate findings of pre-operative examinations and diagnosis with the operative report and pathological findings to check on the necessity for surgery.

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(c) Records Committee - to assist the staff of record departments in the maintenance of standards in the patients' records.

(d) Credential Committee - to review applications for staff appointments and determine the privileges that may be granted to successful applicants; also, to recommend members for promotion when available. Since the advent of Hospital Insurance, additional committees have been necessary to assist in the maintenance of standards and avoid over-utilization of insured services (Standards Committee), to advise on questionable admissions, necessary nursing services, long-stay patients, diagnostic services (Admission and Discharge Committee), and use of drugs (Pharmacy Committee).

3. Nursing Services - Necessary nursing service is provided without cost to the patients under the Nova Scotia Hospital Insurance Act whether they occupy standard ward beds or preferred accommodation. A nurses' training school is operated by 14 hospitals in the Province, and 5 training nursing assistants. (Appendix XI) Most of the hospitals are handicapped by the shortage of nurses.

4. Dietary Services - Many hospitals cannot obtain dietitians.

5. Pharmacy Service - definite shortage of pharmacists.

A patient in an active treatment hospital in Nova

A patient in an active treatment hospital in Nova

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Scotia is entitled to the following services
without charge:

1. Accommodation and meals at the
standard ward level.
2. Necessary nursing services.
3. Laboratory, radiological and other
diagnostic procedures, together with the
necessary interpretation for the purpose
of maintaining health, preventing disease
and assisting in the diagnosis and treatment
of any injury, illness or disability.
4. Drugs, biologicals and related
preparations as specified, when
administered in a hospital.
5. Use of operating room, case room and
anaesthetic facilities including necessary
equipment and supplies.
6. Routine surgical supplies.
7. Use of radiotherapy facilities where
available.
8. Use of physiotherapy facilities where
available.
9. Services rendered by persons who
receive remuneration therefore from the
hospital.

168. It must be noted that satisfactory radio-
logical diagnostic services are being maintained
only by the radiologists carrying an unreasonably
high workload. There is a significant shortage of
radiologists in the Province - another six radio-

without charges:

1. Accommodation and meals at the

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high workload. There is a significant shortage of

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logists are urgently required. Also, seven more pathologists are required to properly supply laboratory needs within the next 5 years.

169. A number of the larger hospitals participate in the clinical training of undergraduate students of Dalhousie Medical School. The Victoria General Hospital, in addition to undergraduate training, provides resident training in Medicine, Surgery, Radiology, Pathology, Bacteriology, Urology, Gynecology, Psychiatry, Neuro-surgery and Therapeutic Radiology. The Children's Hospital trains residents in Paediatrics and partial training in Surgery and Radiology.

170. Convalescent Hospitals. There is one convalescent hospital in Nova Scotia, the Halifax Convalescent Hospital, with 54 bed capacity, operated by the Department of Health of the City of Halifax and participating in the Nova Scotia Hospital Insurance Plan. The medical services are provided by a small staff, who receive honoraria for their services. Patients are accepted only from other hospitals, principally the Victoria General Hospital and the Halifax Infirmary.

171. Chronic Hospitals. There are no hospitals for chronic illness but there are some long-term beds in connection with active hospitals. Long-stay re-activation units of 20 beds or less or being provided in some regional hospitals.

172. Out-patient and Emergency Services. The Province provides the highest coverage in Canada of out-

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Chronic Hospitals. There are no hospitals for chronic illness but there are some long-term beds in connection with acute hospitals. Long-stay residential units of 20 beds or less or below provide in some regional hospitals.

Outpatient and Emergency Services. The Province provides the highest coverage in Canada of out-



1 patient services under the Nova Scotia Hospital
2 Insurance Plan. The following out-patient services
3 are provided without charge to entitled residents:

- 4 1. Complete radiological diagnostic
5 services.
- 6 2. Complete laboratory diagnostic services
7 except for a few of the rarer tests and
8 haemoglobin estimations and urine examin-
9 ations.
- 10 3. Electroencephalographic examinations
11 and the interpretations thereof.
- 12 4. Diagnostic procedures involving the
13 use of radio-active isotopes and the
14 interpretations thereof.
- 15 5. Use of radiotherapy facilities, where
16 available, for the treatment of malignancy.
- 17 6. Use of physiotherapy facilities where
18 available.
- 19 7. Necessary nursing services.
- 20 8. Services, other than medical services,
21 provided by and within the Nova Scotia
22 Tumor Clinic.
- 23 9. Minor Medical and Surgical procedures
24 covering some twenty (20) main categories.

25 173. Alternate Care Programs - e.g. Home Care Programs,
26 Homes for the Aged.

26 There are no home care programs or homes for the aged
27 under the Nova Scotia Hospital Insurance Plan.

28 174. Special Treatment Facilities - e.g. Cardiovascular
29 Units.

30 The urgent and intense need for such facilities is



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- Special Treatment Facilities - e.g. Cardiovascular
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12. Diagnostic procedures involving the
use of radio-active isotopes and the
and the interpretation thereof.
13. Electroencephalographic examinations
ations.
14. Complete laboratory diagnostic service
except for a few of the paper tests and



clearly indicated by two facts. From the opening of the Cardiac Unit of the Victoria General Hospital on April 14, 1958, to September 15, 1961, a total of 765 major cardiovascular diagnostic procedures have been performed. Despite the fact that, for the past year, the Unit has been doing four procedures per week, the cardiac catheterization facilities are booked ahead for a period of three months.

175. The facilities that now exist at the Victoria General Hospital are barely adequate for routine right heart catheterization, left heart catheterization and selective angiocardiology. Since this equipment was installed in 1958, numerous advances in techniques and equipment have been made so that some of the facilities for these procedures are obsolescent. For example, the fluoroscopic equipment requires an image intensifier to decrease the exposure to radiation of personnel and patients. Equipment for cineangiocardiology and facilities for the indicator (dye) dilution technique are required.

176. A major problem in the performance of advanced cardiovascular diagnosis in Nova Scotia lies in the perennial shortage of trained technical personnel. This shortage is the result of the low salary schedules prevalent in this area. Trained technicians travel to other laboratories in Montreal, Toronto and the West, where the salary scales are more generous. It has never been possible for the Victoria General Hospital Cardiac Unit to obtain the

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1 services of a fully trained cardiologist technician,
2 and when one technician resigns, a long period of
3 training is necessary before any replacement can
4 reach suitable degree of proficiency.

5 177. The situation as regards advances cardio-
6 vascular diagnosis in this area is duplicated in the
7 field of surgical treatment. The earliest cardio-
8 vascular surgical procedures were carried out by
9 "closed" methods, e.g. the valve-splitting operation
10 in mitral stenosis. This technique is available at
11 this centre. As time passed and technical
12 improvements were made, cardiovascular surgery with
13 body-cooling techniques (hypothermia) became
14 extremely popular in the correction of a limited
15 number of structural cardiac abnormalities. Such
16 techniques are also available at this centre.
17 During the past decade, however, great strides have
18 been made in what is called open-heart surgery,
19 i.e. heart surgery with artificial circulation or a
20 heart-lung pump. As refinements have continued to
21 be made in this technique, more and more cardiac
22 structural abnormalities have become correctable,
23 and this technique has spread to involve certain
24 types of cardiac abnormalities which were previously
25 corrected by closed methods, especially with the aid
26 of hypothermia. It has now become more and more
27 important for any centre doing advanced cardio-
28 vascular diagnosis and treatment to have facilities
29 for open-heart surgery available. Such facilities
30 are not available at this centre. The result is that

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more and more patients who require cardiac surgery actually require open-heart surgery, and must travel to Montreal, Toronto or the U. S. A. for these procedures. This centre urgently requires a special laboratory where open-heart operations can be done in animals in order to perfect techniques which can then be used with a heart pump to be chosen by the cardiologists and surgeons. After about a year of such investigation, it would be possible to perform open-heart surgery at this centre in humans, and, in addition to a pump required for investigative purposes, one or more additional pumps should be made available for surgical procedures in humans. Technical personnel for the operation and maintenance of these heart pumps will also be required.

178. Therapeutic Radiology. The Therapeutic Radiological Services available in Nova Scotia at present are largely concentrated at the Victoria General Hospital. These conform to the report on "Minimum Standards for Radiation Therapy Centres" by the Advisory Committee on Radiation Therapy of the National Cancer Institute. The Radiation Therapy Department is housed within a building completed three years ago specifically for the needs of the department. As yet, there is no Radiation Therapy ward in the Victoria General Hospital, but it is hoped that such a ward will come into existence.

179. The staff of the unit has facilities for training a physician in radiation therapy, but no applications have been received. It is believed

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laboratory where open-heart operations can be done in animals in order to perfect techniques which can then be used with a heart pump to be chosen by the cardiologists and surgeons. After about a year of such investigation, it would be possible to perform open-heart surgery at this centre in humans, and, in addition to a pump required for investigative purposes, one or more additional pumps should be made available for surgical procedures in humans. Technical personnel for the operation and maintenance of these heart pumps will also be required.

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1 that the income for residents of \$125.00 per month
2 is not sufficiently attractive, when by going
3 elsewhere in Canada \$500.00 is received.

4 180. Radiation therapy facilities are available
5 at the Halifax Infirmary. It is the intention of
6 the hospital to set up a separate department of
7 radiation therapy at the institution. A superficial
8 X-ray machine is in operation at the Dartmouth
9 Medical Centre. Facilities for deep and superficial
10 radiation therapy have been available in the past
11 at St. Elizabeth Hospital, North Sydney. The
12 equipment is still there, as is a superficial X-ray
13 machine at New Glasgow.

14 181. Radio-isotopes. A training school for isotope
15 technicians was inaugurated in September, 1961.
16 These students will undergo a combined course of
17 laboratory training in association with the
18 Pathological Institute. Physics, radiation,
19 protection, physiology and electronics are taught in
20 our own Department (2 trainees per year). A
21 training school for radiation therapy technicians
22 was established in 1959 (2 trainees per year).

23 THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT

24 182. History and Current Operation. The Hospital
25 Insurance and Diagnostic Services Act became operative
26 in Nova Scotia on January 1st, 1959. Now with two
27 and one-half years experience one can say that it has
28 operated exceedingly well and problems have not been
29 as great as were expected.

30 183. We would believe that it has been due to

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is not sufficiently attractive, when by going

elsewhere in Canada \$500.00 is received.

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at the Halifax Infirmary. It is the intention of

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THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT

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in Nova Scotia on January 1st, 1959. Now with two

and one-half years experience one can say that it has

operated exceedingly well and problems have not been

as great as were expected.

We would believe that it has been due to



careful preliminary planning done mutually by the Department of Health, The Nova Scotia Medical Society, The Nova Scotia Hospital Association, The Registered Nurses Association and other interested bodies. One and one-half years before the actual initiation of the service, the government set up a Hospital Planning Commission and the other organizations mentioned set up advisory committees who were to study the problems and co-operate with the Government Planning Commission. The Advisory Committee of the Nova Scotia Medical Society, worked intensively for a period of two years in close co-operation with the other bodies.

184. It can be concluded that the successful operation of the Hospital Plan in this Province has resulted from careful joint planning which demanded many hours of voluntary service contributed by the Nova Scotia physicians and other interested parties. Shortly after the inauguration of the scheme, The Hospital Insurance Commission set up a Professional Technical Advisory Committee (P. T. A. C.). This Committee has been active in an advisory capacity to the Commission and has considered a great many problems in the professional and technical field. It has also served as a quality control board. It should, perhaps, be noted that in our experience the most troublesome areas in the operation of the Hospital Plan have been when doctor services were being provided.

185. Its Effects. What have been the results of this



1 scheme? In general one has the impression that they
2 have been good and that many individual Nova
3 Scotians have been relieved of great insecurity
4 resulting from hospital bills. However, the increase
5 in January, 1961 of the Provincial sales tax from
6 3% to 5% to meet increasing costs is ample refutation
7 of any talk of "free hospitalization". The cost of
8 tuberculosis and mental hospital beds is not
9 included. This increase is not greater than fore-
10 seen by the Planning Commission.

11 186. Some factors in this increased cost are
12 greater utilization of services and longer hospital
13 stay. Figures are available to indicate the increase
14 in radiological services coinciding with organization
15 of the diagnostic scheme and radiologists in this
16 Province are carrying upwards to one hundred and
17 fifty percent of their optimum work load. Further,
18 despite the addition of more hospital beds in the
19 Province, the waiting lists have gradually increased.
20 At the Victoria General Hospital the waiting period
21 is two months or more for elective surgery and
22 medicine. No one would argue that such conditions
23 represent "high quality medical care" - many would
24 argue that they are temporary and with more
25 personnel and hospital beds would automatically
26 correct themselves. Maintenance and improvement of
27 quality medical services under Hospital Insurance is
28 in large measure dependent on the integrity and
29 co-operation of the medical profession. This is
30 supported by statements of leaders in Public Health

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1 which attribute much of the success of the plan to
2 the co-operation of the doctors.

3 187. The concensus in Nova Scotia would support
4 the view that conditions for undergraduate and post-
5 graduate medical teaching have improved. Teaching
6 at both levels is largely centered around Dalhousie
7 University. There are teaching beds at the Victoria
8 General Hospital, the Halifax Infirmary, Children's
9 Hospital, Camp Hill Hospital, the Grace Maternity
10 Hospital and the Canadian Forces Hospital in
11 Halifax. Increase in medical service demands more
12 doctors and maintenance of quality demands that
13 those doctors have adequate training and
14 opportunity. Such can only be provided when the
15 medical teacher has an adequate supply of patients
16 who have a diversity of conditions. These points
17 are of vital importance when planning future health
18 services.

19 SUMMARY OF TERM (a)

20 188. The foregoing review of "facilities and
21 methods for providing personal health services" as
22 they apply in Nova Scotia, demonstrates the range
23 of services which have developed and are developing
24 in the ever continuing endeavor to provide high
25 quality health services to the individual, the
26 family and the community.

27 189. Within this complex of "facilities and
28 methods" are two factors, which have remained and
29 will continue to remain constant. These are the
30 patient who needs and wishes to have medical services

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1 and the doctor who provides them. While it is true
2 that personal medical services provided by the
3 doctor would be relatively limited were it not for
4 hospital, para-medical, and technical services
5 available to him, the patient in his community and
6 the doctor are nevertheless the solid basis of
7 present and future health services.

8 190. As the barriers of ignorance were assaulted,
9 particularly during the last hundred years, by
10 medical and scientific advances, the knowledge gained
11 thereby has been put to practical application in so
12 far as facilities and financial support have made
13 it possible. One result has been the creation of a
14 demand to have such health services more readily
15 available. Voluntary effort has been noteworthy
16 in establishing agencies to assist in meeting the
17 demand. In some instances, government has
18 participated, and in other government has taken
19 full responsibility. The developing social
20 conscience has contributed in no small measure to
21 this trend. What has been accomplished results
22 from the co-ordinated efforts of all interested
23 groups.

24 191. Progress has also taken place in other
25 fields and we find access to health services has
26 much improved. Better roads, better methods of
27 transportation and communication each serve to make
28 services more available to all areas in Nova Scotia.

29 192. In preventive medicine we have the
30 essentials of good departmental and regional

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1 administration. Individual physicians support the
2 work of recognized agencies and they apply in their
3 own practices the procedures which prevent such
4 diseases are are amenable to this approach.

5 193. Diagnosis and treatment are the very core
6 of personal health services and they call for the
7 exercise of high intellectual functions and the
8 application of professional skills. A profession
9 basically well trained and afforded the opportunity
10 to refresh its knowledge constantly, brings to its
11 task the resources which are available. The demands
12 for the services of general practitioners and
13 specialists are being just adequately supplied under
14 current conditions. This is achieved by the
15 devotion of physicians whose hours of work
16 considerably exceed those of many others and by
17 their willingness to provide their services on the
18 basis of need. We recognize that the general
19 physician-population ratio is low and that in certain
20 specialties definite shortages exist. Aids to
21 diagnosis in the form of radiological and pathological
22 services are available under Hospital Insurance on
23 both an in-patient and an out-patient basis. These
24 services have been increasingly in demand with the
25 result that additional personnel and equipment are
26 required to bring them to optimum efficiency. The
27 provision of additional hospital beds of all types
28 will be emphasized under subsequent headings.

29 194. In the fields of rehabilitation and mental
30 health, we are sadly deficient and more trained

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In the fields of rehabilitation and mental health, we are sadly deficient and more trained



1 personnel, more money, more buildings and more
2 understanding are required to cover the area of
3 personal health services reasonable adequately.

4 195. Our view, taking present experience and
5 facts into consideration, is that for the immediate
6 future attention should be directed to supplementing
7 basic medical services with the physical facilities
8 and personnel necessary to develop medical services
9 to their full potential.

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future attention should be directed to supplementing
basic medical services with the physical facilities
and personnel necessary to develop medical services
to their full potential.

- 1 TERM (b) "METHODS OF IMPROVING SUCH HEALTH SERVICES"
- 2 196. We have pointed out under your first
- 3 specific term of reference the existing facilities
- 4 and methods, private and public, which have a
- 5 bearing on the provision of present health services.
- 6 In the process we have commented on their adequacy
- 7 and have suggested those areas which demand
- 8 improvement in the interests of service of a high
- 9 quality.
- 10 197. In summary, advances in knowledge and in
- 11 aids to diagnosis have resulted in the ability to
- 12 identify changes from normal at an earlier state in
- 13 their development. Similar advances have led to
- 14 improvement in therapeutics. The practical
- 15 implementation of those advances is dependent on
- 16 medical services, physical facilities and the
- 17 associated personnel with para-medical training
- 18 being available.
- 19 198. Methods of improving such health services
- 20 include the following:- Proceeding with the studies
- 21 already initiated (Community Medical Manpower in
- 22 Nova Scotia and the Community Survey) to ascertain
- 23 the actual distribution and the need for general
- 24 practitioners and consultants or specialists'
- 25 services in Nova Scotia, especially the rural areas.
- 26 This study would be on the geographic basis of the
- 27 established health units. Improvement in the
- 28 distribution of medical services would depend on
- 29 several factors such as subsidization of the doctor,
- 30 where necessary, development of physical facilities

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distribution of medical services would depend on

several factors such as subsidization of the doctor,

where necessary, development of physical facilities



1 and access to laboratory and trained personnel.

2 199. The well accepted and established services
3 by the Department of Public Health in Nova Scotia,
4 particularly those associated with preventive
5 services, should be re-examined to be made as
6 effective as possible in association with clinical
7 services. We are aware that a study of the Department
8 of Public Health is under way, aided by a federal
9 health grant.

10 200. The economic problem of financing services
11 of physicians has been elaborated and we have
12 recommended the expansion of medical services
13 insurance as a method for its solution. We visualize
14 a comprehensive plan of medical services insurance
15 as being available to every resident of Nova Scotia
16 through a combination of private and public
17 financing.

18 201. A good deal of our descriptive material has
19 related to the role of private medical practice in
20 the provision of personal health services. We
21 readily acknowledge that improvements are necessary
22 for the full development of the services rendered in
23 this category. We state, however, that a wide range
24 of professional activities are at work with this end
25 in view and that continuous improvement is taking
26 place. Much of this improvement is dependent on the
27 knowledge and the integrity of the individual
28 medical practitioner. Your sympathetic attention to
29 the needs of medical education, which are elaborated
30 elsewhere, will be more than helpful in improving

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the needs of medical education, which are elaborated

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1 more than one aspect of this situation, the
2 provision of adequate numbers of well trained
3 doctors to man our expanding services.

4 202. We have commented at some length on the
5 health services provided by the official agencies of
6 all levels of government. Much of our comment has
7 been favourable and in many of these services the
8 forces already at work will operate to ensure their
9 progressive improvement. There are, however, areas
10 of traditional government responsibility which
11 appear to have been lagging in the onward march
12 which require considerable amendment to institute
13 improvements. One such area relates to mental health
14 and we have incorporated a number of specific
15 recommendations to accomplish the necessary
16 improvements. Another large area which deserves
17 much more aid from government and semi-official
18 agencies is that related to rehabilitation. We have
19 listed several recommendations with a view to
20 instituting improvements and we commend them to your
21 attention. The control of cancer, too, has exhibited
22 notable deficiencies and proposals for their
23 correction have been made.

24 203. Methods of improving the health services
25 which have been studied reveal that a considerable
26 degree of co-operation between health workers,
27 particularly the medical profession, and official
28 agencies of the government is essential. We have
29 demonstrated that the co-operation has applied in
30 the past and that together we have provided services

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1 of high quality, sometimes with limited resources.
2 The methods here outlined require a full
3 appreciation of the need for progressive improvement
4 and in many instances, the allocation of more
5 adequate public funds.

6 204. Public policy as interpreted by governments
7 are political parties requires clear thinking on
8 the relative importance of health services to all
9 other needs of the people. The Medical Society of
10 Nova Scotia, not unnaturally, regards the provision
11 of improved health services as an objective of
12 primary importance. This can be best achieved by
13 recognition that medicine has the responsibility
14 for conducting medical education and medical
15 services as well as the maintenance of the quality
16 of medical services.

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1 TERM (c) "THE CORRELATION OF ANY NEW OR IMPROVED
2 PROGRAM WITH EXISTING SERVICES WITH A
3 VIEW TO PROVIDING IMPROVED HEALTH
4 SERVICES".

5 205. We take the position that rather than
6 extensive new programs being required to provide
7 improved health services, improvements and
8 extension of existing programs will require less
9 long term outlay and result in a more rapid gain in
10 quality care.

11 206. The deficiencies in physical facilities
12 elaborated under Term (f) can be corrected by a
13 modification of the present machinery for sharing
14 costs through Federal-Provincial grants and
15 community financing. Where the universities are
16 involved, grants from foundations, industry and the
17 voluntary agencies may be expected to contribute,
18 as they have in the past, both to the provision of
19 new departments and to the subsidization of graduate
20 study and research. But the need of medical education
21 is so great that large contributions from all levels
22 of government will be essential.

23 207. We think that there is required a
24 correlation of the efforts of the voluntary agencies,
25 to prevent possible duplication and to strengthen
26 the aid that these agencies give to health care. We
27 would cite the Nova Scotia Rehabilitation Council
28 as a step in this direction. (Appendix XVI).

29 208. Correction of the deficiencies in services
30 that have been noted throughout our submission, and
particularly those in the fields of mental health,

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that have been noted throughout our submission, and
particularly those in the field of mental health,



1 rehabilitation and the care of the chronically
2 incapacitated require particular attention. Many
3 improvements are already planned by or through the
4 Department of Health of the Province, notably in the
5 proposed additional Mental Health Centres, the
6 reorganization of Municipal Mental Hospitals, and in
7 the approval of a financial commitment for the
8 addition of active and long-stay treatment beds.

9 209. Improvements in the prevention and
10 treatment of alcoholism, the reduction of traffic
11 accidents, in the prevention and treatment of
12 poisoning in childhood, in recreation and physical
13 fitness, can be built upon the present governmental
14 and professional structures.

15 210. Our recommendation that voluntary,
16 comprehensive medical insurance coverage be available
17 to all citizens of the Province, with government
18 participation, requires no new approach. A non-
19 profit professional plan, Maritime Medical Care
20 Incorporated, has established its position as a
21 carrier through acceptance by a considerable
22 proportion of the population and its consequent
23 growth. Moreover, the Province, through its
24 agreement with the Medical Society, has indicated
25 its recognition of the usefulness of the plan, and,
26 by its financial contribution of the premium by
27 9,832 of those receiving Social Assistance, its
28 recognition of the principle of governmental
29 participation. Further participation to provide
30 coverage for the indigent of the Province and a

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9,632 of those receiving Social Assistance, its
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participation. Further participation to provide
coverage for the indigent of the Province and a



1 graded scale of contributions for those of low
2 income, would present no true problem other than to
3 find the financial resources. Although this would
4 be a substantial figure, it would be proportionately
5 small in relation to the total cost of health care
6 currently provided in Nova Scotia. However, it
7 would be substantial enough to underline the wisdom
8 of making the availability of medical services
9 insurance voluntary so that the self-supporting
10 citizens of the Province who have the financial
11 ability to pay for their physicians' services may
12 either elect to do so directly or through the
13 prepaid plan.

14 211. We reiterate that an examination of these
15 methods of improving health services will substantiate
16 our view that improvement can be brought about
17 expeditiously and without interference with the
18 traditional patient-doctor freedoms associated with
19 the private practice of medicine.
20
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the private practice of medicine.

1 TERM (d) "THE PRESENT AND FUTURE REQUIREMENTS OF
2 PERSONNEL TO PROVIDE HEALTH SERVICES".

3 212 The Canadian Medical Association is
4 preparing studies on medical manpower on a national
5 basis, for both general practitioners and specialists.
6 It is also understood that your Commission has
7 initiated studies on para-medical personnel. We
8 wish to emphasize certain features that are of
9 special concern to this Province and indeed to the
Atlantic Provinces as a whole.

10 213. The ratio of population per physician is
11 less favorable in this region than in the rest of
12 Canada. The number of active resident physicians in
13 Nova Scotia at December 31st, 1960, was 719. This
14 is a ratio of 1,013 persons per physician as
15 compared with the Canadian ratio of 879 persons per
16 physician. More than 100 additional physicians
17 would be needed immediately in this area to reach
18 the present Canadian average. However, the
19 Canadian average does not constitute an ideal figure
20 as there are shortages in other provinces too.
21 More study is required to make an accurate
22 prediction of the need for professional personnel,
23 particularly in the event that medical services
24 insurance plans are expanded. The Canadian Sickness
25 Survey (1950-51), presents some information which
26 may be of value. The following comparison by
27 region of the volume of physicians' services (home
28 and office calls) shows the Maritimes to be
29 approximately 14 per cent below the Canadian average,
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and 31 per cent below the highest figure in the Province of British Columbia.

Table 1

Number of Doctors' Calls (Home and Office,
excluding Clinic) per 1,000 per year of
Population by Region

British Columbia	2,052
Ontario	1,990
Quebec	1,524
Maritimes	1,418
Prairies	1,298
Newfoundland	687
Canada	1,646

214. A comparison of the volume of physicians' services to medically insured populations shows an even more striking deficit so far as the Maritimes are concerned. Families with some form of medical insurance in the Sickness Survey had 2,154 physicians' services per thousand persons per year. At approximately the same period the Swift Current population, covered by a publicly financed insurance plan, had 2,340 physicians' services per thousand. Three Voluntary Canadian Medical Insurance Plans provided 2,150 physicians' services per thousand subscribers during that period. Present figures from Maritime Medical Care Incorporated show a ratio of 3,254 physicians' services per thousand insured persons, excluding physicians' services in hospital,

and 31 per cent below the highest figure in the Province of British Columbia.

Table 1

Number of Doctors, GPs (Home and Office),
excluding Clinics) per 1,000 per year of
Population by Region

British Columbia	2,022
Quebec	1,524
Maritimes	1,418
Prairies	1,298
Newfoundland	687
Canada	1,646

214.

A comparison of the volume of physicians' services to medically insured populations shows an even more striking deficit so far as the Maritimes are concerned. Families with some form of medical insurance in the Sickness Survey had 2.124

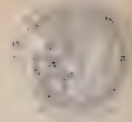
At approximately the same period the Swiss Current population, covered by a publicly financed insurance plan, had 2,340 physicians' services per thousand. These figures, however, are not comparable with the present figures from Maritime Medical Care Incorporated show a ratio of 3,224 physicians' services per thousand insured persons, excluding physicians' services in hospital.



1 minor surgery in the doctor's office, specialist
2 consultations, special diagnosis procedures and
3 well-baby care. If these are included, the ratio
4 is 3,720 doctors' services per thousand. These
5 figures from the various sources would seem to show
6 that the volume of physicians' services in the
7 Maritime Provinces will certainly increase from the
8 1950-51 level of 1,418 physicians' services per
9 thousand persons. It might be expected to reach at
10 least the levels for other insured groups,
11 approximately 2,100 to 2,300 and might be much
12 higher as evidenced by the Maritime Medical Care
13 figures. If the former level were reached, the
14 increase of physicians' services over the present
15 level might be 50 per cent, and if the latter is
16 a better guide, the volume would more than double.

17 215. We would emphasize that a very large
18 increase in the number of physicians would seem to
19 be indicated if the population of this area is to be
20 given the same level of medical services now
21 provided to insured populations. However, up-to-date
22 information on which an accurate estimate can be
23 based, is not available. We know that 100 more
24 physicians would be needed to reach the Canadian
25 ratio. A fifty per cent increase based on the above
26 data from insurance plans, would require an increase
27 of more than 300 physicians.

28 216. We would also emphasize that it takes ten
29 to twelve years to achieve appreciable increase in
30 the supply of Canadian trained physicians. Taking



minor surgery in the doctor's office, specialist
consultations, special diagnostic procedures and
well-baby care. If these are included, the ratio
of 1.75 to 1.00 would be indicated. These
figures from the various sources would seem to show
that the volume of physicians' services in the
Maritime Provinces will certainly increase from the
1950-51 level of 1,418 physicians' services per
thousand persons. It might be expected to reach at
least the levels for other insured groups,
approximately 2,100 to 2,300 and might be much
higher as evidenced by the Maritime Medical Care
Program. At the same time, it is possible that
the volume of services will be less than in the
other groups, and in the future it
a better guide, the volume would more than double.
We would emphasize that a very large
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be indicated if the population of this area is to be
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provided to insured populations. However, up-to-date
information on which an accurate estimate can be
based, is not available. We know that 100 more
physicians would be needed to reach the Canadian
ratio. A fifty per cent increase based on the above
data from insurance plans, would require an increase
of 100 more physicians.
We would also emphasize that it takes ten
to twelve years to achieve appreciable increase in
the supply of Canadian trained physicians. Taking



1 into account the length of the premedical and
2 medical courses of three and five years
3 respectively, there is a need for expanding the
4 physical facilities in medical schools, the
5 recruitment and training of more medical teachers
6 and the recruitment of more medical students.

7 217. Factors influencing the recruitment of
8 future medical personnel require careful and
9 objective study. Certainly the long and expensive
10 medical course would seem to be one factor.
11 Following World War II a considerable proportion of
12 the veteran students would not have had a university
13 education without the Federal Government grants to
14 veterans. Most of these who studied medicine made
15 excellent doctors. It seems reasonable to believe
16 that there are many able young men and women being
17 deprived of a university education for lack of
18 similar support. The increase in enrolment at
19 Dalhousie University Medical School from Newfoundland
20 since the introduction of assistance to medical
21 students two years ago, suggests one method of
22 solving the problem. Unnecessarily rigid Government
23 regulations for repayment of bursaries by specified
24 services tend to decrease the value of such
25 incentives. With the rapid increase in medical
26 knowledge, we cannot foresee how the undergraduate
27 medical course could be reduced in length.



217.

medical courses of three and five years respectively, there is a need for expanding the physical facilities in medical schools, the recruitment and training of more medical teachers and the recruitment of more medical students. Factors influencing the recruitment of future medical personnel require careful and objective study. Certainly the long and expensive medical course would seem to be one factor. Following World War II a considerable proportion of the veteran students would not have had a university education. Most of these who studied medicine made excellent doctors. It seems reasonable to believe that the lack of a university education for lack of similar support. The increase in enrollment at Dalhousie University Medical School since the introduction of assistance to medical students has been very marked. Unnecessarily rigid Government regulations for repayment of bursaries by specified services tend to decrease the value of such incentives. With the rapid increase in medical knowledge, we cannot foresee how the undergraduate medical course could be reduced in length.



1 TERM (e) "METHODS OF PROVIDING ADEQUATE PERSONNEL WITH
2 THE BEST POSSIBLE TRAINING AND QUALIFICATIONS
3 FOR SUCH SERVICES".

4 218. Once licensed by the Provincial Medical
5 Board of Nova Scotia, the maintenance of standards
6 is a personal responsibility of the individual
7 doctor of medicine, aided as he is by the university
8 and the voluntary bodies of the profession.

9 219. Facilities for full time specialist
10 training exist in Nova Scotia in the teaching
11 hospitals affiliated with the Faculty of Medicine,
12 Dalhousie University. These are in regular use by
13 approximately fifty recent graduates of medicine.

14 220. Facilities for full time general
15 practitioner training are available in the same
16 institutions but have been infrequently utilized
17 and for inadequate periods of time. Lack of
18 recognition of the training received, not only by
19 their professional confreres but by their patients,
20 are the reasons advanced by candidates who have
21 refused appointments as general practice rotating
22 interne in the above mentioned teaching hospitals.

23 221. We believe that general practitioner
24 residency training posts should be established in
25 numbers at least equalling those available for
26 specialty training and that incentives to licensed
27 practitioners to take such residency training be
28 developed to include professional and public
29 recognition and social security during such training.

30 222. Reviews of advances in medical knowledge
during the first half of the twentieth century

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Reviews of advances in medical knowledge

222.

during the first half of the twentieth century

1 indicate an exponential expansion. The result is
2 that the practitioner of medicine becomes seriously
3 lacking in his knowledge of recent advances in five
4 years and very seriously, even dangerously lacking,
5 within ten years of his graduation from medical
6 school unless he continues regular study. The
7 practitioner is primarily dependent upon medical
8 texts and current journals. As these have increased
9 in numbers and become more readily available, the
10 selection of the most appropriate among them has
11 been made increasingly difficult for the busy
12 practitioner. As a result, there has been a growing
13 trend to supplement reading by attendance at formal
14 teaching exercises for practising doctors, in an
15 attempt to avoid otherwise inevitable professional
16 obsolescence. It is only by such activity on the
17 part of the individual practitioner that the
18 advances produced by wide ranging medical research
19 can be translated into individual patient care by the
20 practitioner.

223. The Medical Society of Nova Scotia promotes
21 continuing education for the practising physician as
22 follows:-

- 23 1. A Standing Committee of the Society co-
24 operates with the Post-Graduate Division of the
25 Faculty of Medicine, Dalhousie University in the
26 conduct of meetings throughout Nova Scotia.
- 27 2. A representative of the Society sits on
28 the Advisory Committee of the Post-Graduate Division
29 of the Faculty of Medicine, Dalhousie University.
- 30

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2. A representative of the Society sits on the Advisory Committee of the Post-graduate Division of the Faculty of Medicine, Dalhousie University.



3. A per member contribution is paid annually to this University Division by the Medical Society in partial support of their program of continuing education for practising physicians in the four Atlantic Provinces.

4. The Medical Society of Nova Scotia pays to the Post-Graduate Division of the Faculty of Medicine an additional annual grant for post-graduate education received from the Canadian Medical Association.

5. Monthly publication of the Nova Scotia Medical Bulletin.

224. The Medical Society thus indicates by these activities:

1. That continuation of medical education is an essential requirement for the practice of medicine.

2. That continuation of medical education is best carried out by the Faculty of Medicine of a University with the advice and active support of organized medicine.

225. We believe that provision for fifty hours of formal continuation medical education annually for each practitioner of medicine is considered an essential part of the provision of adequate health services.

226. The Medical Society of Nova Scotia finds that the practitioner in Nova Scotia is caring for more patients than the average across Canada. This Society is thus particularly aware of the



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1 of the necessity of training more doctors of
2 medicine. Having had experience with the increased
3 numbers of trained psychiatrists resulting from
4 federal health grants and support of psychiatric
5 specialty training, this Society feels that
6 subsidization of the undergraduate medical student
7 will increase the numbers of doctors. It is
8 considered essential that any subsidization be
9 dependent on the maintenance of high quality work
10 by the medical student receiving it and that it be
11 not unduly restricting on his long term career in
12 the practice of medicine.

13 227. The effect on enrolment of medical students
14 of the government's interest in medical service
15 insurance is not yet apparent to this Society. The
16 intimate character of the classical doctor-patient
17 relationship has a strong attraction for the highly
18 motivated student brought up in the best tradition
19 of the Judeo-Christian philosophy. The effect of
20 government interest on enrolment will be favorable
21 only if preservation of this privacy is kept
22 paramount in government planning.

23 228. The effects of hospital insurance on post-
24 graduate training have been favorable. A prolonged
25 intensive period of co-operative planning between
26 government, hospital administration and organized
27 medicine in Nova Scotia led to recognition of the
28 special requirements of the teaching hospital. In
29 the United States, and in some areas in Canada, where
30 public pressures rather than informed careful

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1 planning have been dominant, experience has been
2 that the training of resident doctors in hospitals
3 has been seriously interfered with by hospital
4 insurance schemes.

5 229. We are well aware of the need for teaching
6 beds and outdoor patients in the hospitals
7 affiliated with the Medical Faculty of Dalhousie
8 University. We consider the ample facilities of
9 this type are essential features in the provision of
10 the best possible training for the qualification of
11 competent personnel to provide medical and allied
12 health services in Nova Scotia.

13 230. Many practitioners have indicated that
14 inability to leave their practices for a week or
15 more, has prevented their attending post-graduate
16 courses. They cite difficulties in arranging for
17 patient care, in procuring a locum tenens, loss of
18 income, and the incurring of out-of-pocket living
19 expenses and tuition fees as major factors in this
20 failure to take needed current training. They
21 maintain that income tax relief in connection with
22 all these expenses would aid significantly in their
23 efforts to combat professional obsolescence.

24 231. The Medical Society of Nova Scotia recommends
25 that out-of-pocket expenses and tuition fees paid
26 for approved post graduate medical education be a
27 deductible expense under the Income Tax Act. We
28 support the efforts of the Canadian Medical
29 Association and the College of General Practice of
30 Canada, to have such expenses recognized as deductible
items.



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beds and outdoor patients in the hospitals affiliated with the Medical Faculty of Dalhousie University. We consider the ample facilities of this type are essential features in the provision of health services in Nova Scotia.

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Canada, to have such expenses recognized as deductible



TERM (f) "THE PRESENT PHYSICAL FACILITIES AND THE
FUTURE REQUIREMENTS FOR THE PROVISION OF
ADEQUATE HEALTH SERVICES".

232. 1. Hospital Facilities. Extensive studies
have been made by the Department of Public Health
and the Hospital Insurance Commission of the
existing hospital facilities and the estimated
future requirements under a hospital insurance plan.
The Medical Society of Nova Scotia was represented
on the Health Survey Committee appointed by the
Department of Public Health in 1948-49. The report
of this Committee and later reports of other
Committees and Commissions provide much information
concerning the hospital facilities of this Province.

233. These reports also record the efforts to
establish standards for estimating future hospital
bed requirements. When the first survey of hospitals
was made in 1948-49 there were no recognized
standards for estimating hospital needs. A few
arbitrary ratios had been proposed in the professional
journals but with relatively little or no data to
support them. After a study of all of these
proposed standards it was decided to encourage the
building of hospital facilities in Nova Scotia to a
level which would provide an average of 2,150
patient-days of hospital care per thousand of
population in active and long-term hospitals. This
is equivalent to 6.9 beds per thousand population,
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1 234. We consider it extremely important that
2 the general hospital facilities of the Province be
3 built up as rapidly as possible to the average of
4 6.9 beds per thousand of population. We think this
5 standard is not too high and in a few areas may even
6 be a little low. It should be used only as an
7 initial estimate of the bed requirements of a
8 community with adequate attention given to local
9 factors which may affect the size of the hospital.

10 235. We think it is reasonable to enquire why
11 this Province finds itself very short of hospital
12 beds almost three years after the introduction of
13 hospital insurance and thirteen years after the
14 hospital construction grants by the Department of
15 National Health. Failure to provide the required
16 hospital beds before hospital insurance was intro-
17 duced seems to have been due in part to the
18 inadequacy of the Federal Construction Grant, which
19 provided only a small fraction of the total cost.
20 The fact that is also required a matching
21 contribution by the Province resulted in the
22 Government of Nova Scotia withdrawing from the use
23 of this grant for several years. It is understood
24 that the stated reason for refusing to use this
25 grant was the fact that Nova Scotia had already
26 reached the Canadian average in hospital beds per
27 thousand population. The earlier reports to the
28 Government had indicated that the Canadian average
29 was far below the standard which would be necessary
30 if a hospital insurance plan were introduced. The



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was far below the standard which would be necessary
if a hospital insurance plan were introduced. The



decision to accept the Canadian average as adequate must now be considered as short-sighted.

236. In any event, the outcome was that hospital beds were increased from 2,386 in 1950 to 3,422 in 1959, a sizable increase but much less than the approximately 5,000 beds needed for a comprehensive hospital insurance program. Table 1 shows a comparison between Nova Scotia and other provinces in the ratio of beds to population, at the present time, more than two years after the introduction of hospital insurance in this Province.

Table 1
Comparison between Nova Scotia and other Provinces
in Ratio of Beds to Population in 1961.

Provinces	Rated Capacity of Public General Hospitals*	Estimated Population of Province**	Beds per 1000 Population
British Columbia	8,581	1,644,000	5.2
Alberta	7,599	1,327,000	5.7
Saskatchewan	6,366	916,000	6.9
Manitoba	4,431	914,000	4.8
Ontario	29,338	6,228,000	4.7
Quebec	22,824	5,227,000	4.4
New Brunswick	2,999	611,000	4.9
Nova Scotia	3,563	732,000	4.9
Prince Edward Island	700	105,000	6.9
Newfoundland	1,815	471,000	3.9

* Canadian Hospital Directory 1961.

** D.B.S. Intercensal estimate June 1, 1961.

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decision to accept the Canadian average as adequate must now be considered as short-sighted.

In any event, the outcome was that hospital beds were increased from 2,386 in 1950 to 3,422 in 1952, a stable increase but much less than the approximately 5,000 beds needed for a comprehensive hospital insurance program. Table I shows a comparison between Nova Scotia and other provinces in the ratio of beds to population, at the present time, more than two years after the introduction of

TABLE I
Ratio of Beds to Population in 1951

Province	Rated Capacity	Estimated	Beds per 1,000
British Columbia	8,581	1,644,000	5.2
Saskatchewan	6,366	916,000	6.9
Manitoba	4,431	914,000	4.8
Ontario	29,338	6,228,000	4.7
New Brunswick	2,999	611,000	4.9
Nova Scotia	3,563	722,000	4.9
Newfoundland	1,815	471,000	3.9

** D.B.S. Intercessal estimate June 1, 1951.



Saskatchewan provides a useful guide. The ratio is now 6.9 per thousand. British Columbia, which has also had a hospital insurance plan for some years, has 5.2 beds per thousand, but lacks chronic care facilities.

238. Table 2 shows the ratio of hospital beds to population in 1959 when hospital insurance began and the ratio which may be reached if all construction now under consideration (see Table 4) can be completed by 1965.

Table 2

Number of Hospital Beds per 1,000 population in Each
Hospital Region in 1959 and Estimated Number in 1965

Hospital Region	1959 Population (1)	Bed Capacity 1959	Beds per 1,000 1959	1965 Population (2)	Estim'd Beds 1965	Ratio per 1,000 1965
Atlantic	267,325	1122	4.2	297,794	1,790	6.0
Southern	36,397	108	3.0	36,401	205	5.6
Western	52,166	109	2.1	50,636	293	5.8
Fundy	68,133	247	3.6	71,742	461	6.4
Cobequid	34,350	119	3.5	36,474	225	6.2
Cumberland	32,984	132	4.0	32,996	207	6.3
Pictou	40,861	252	6.2	41,966	252	6.0
Eastern	28,125	235	8.4	29,026	235	8.1
Cape Breton	155,658	1,098	7.0	159,071	1,210	7.6
Total N.S.	715,999	3,422	4.8	756,106	4,878	6.4

(1) Based on D.B.S. estimated population of each region distributed in proportion to residents of the region hospitalized in 1959.

The ratio is now 6.9 per thousand. British Columbia, which has also had a hospital insurance plan for some years, has 5.2 beds per thousand, but lacks chronic care.

Table 2 shows the ratio of hospital beds

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Table 2

Number of Hospital Beds per 1,000 population in each

	1959	1965	Revised Ratio	Number in 1965
Atlantic	267,325	1122	297,794	1,790 6.0
Southern	36,397	108		
Central	24,115	102		293 2.8
Prongy	68,133			
Coquid	34,350			
Cumberland	32,984			
Piston	40,861			
Eastern	28,125	235		
Cape Breton	155,658	1,098		

Total N.S. 715,999 4,878 6.4

(1) Based on D.B.S. estimated population of area region distributed in proportion to residents of the



(2) Based on projection of census of 1951 and 1956 to 1965 and on distribution of patients by region in 1960.

239. This table shows that there was a considerable shortage of hospital beds in some regions when hospital insurance was introduced. It also shows that only two of the nine areas will have reached the proposed standard of 6.9 beds by 1965 on the completion of construction now being planned. Furthermore, it shows that additional facilities had to be provided in Cape Breton Island which will bring the ratio above 6.9 per thousand. The same already pertained in 1959 in the Antigonish-Guysborough area.

240. Table 3 shows the number of hospital beds in Nova Scotia from 1950 to 1959. During that period there was an increase from 2,386 to 3,422, a gain of 1,036 beds.

Table 3

Hospital Bed Facilities in Nova Scotia
1950 to 1959

<u>Year</u>	<u>Number of Beds</u>
1950	2,386
1953	3,000
1956	3,332
1959	3,422

241. By 1961 the total figure has increased to 3,589. New hospitals or additions to existing hospitals which are now under construction, will

(2) Based on projection of census of 1951 and 1956 to 1965 and on distribution of patients by region in 1960.

This table shows that there was a considerable shortage of hospital beds in some regions. It also shows that only two of the nine areas will have reached the proposed standard of 6.9 beds by 1965 on the completion of construction now being planned. Furthermore, it shows that additional facilities had to be provided in Cape Breton Island which will bring the ratio above 6.9 per thousand. The table also shows that in the Miramichi-Guyaborough area.

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Table 3

Hospital Bed Facilities in Nova Scotia

1950 to 1959

Year	Number of Beds
1950	2,386
1959	3,422

By 1961 the total figure has increased to 3,589. New hospitals or additions to existing hospitals which are now under construction, will

increase the capacity by an additional 377 beds, bringing the total to 3,966. Additions planned for the future, but not yet under construction in 19 hospitals, as shown in Table 4, will result in a further net increase of 793 active treatment beds and 119 long-stay or chronic beds.

Table 4

Additions Planned but not under Construction

		Total Beds Approved by Commission	No. of Beds in Existing Hospital	Net Increase in Active	Capacity Long-Stay
12	All Saints	62	43	19	
13	Annapolis General	27	14	13	
14	Blanchard- Fraser	138	65	30	
16	Colchester County	200	105	75	20
17	Dawson				
18	Memorial	83	43	40	
19	Digby General	90	28	62	
20	Eastern Shore				
21	Memorial	34	26	8	
22	Fisherman's Memorial	70	34	36	
23	Highland View	116	62	42	12
24	Lillian Fraser	25	14	11	
25	Mayzant Memorial	132	74	36	20
26	Queens General	52	31	21	
27	Sacred Heart	50	42	8	
28	Saint Anne	25	14	11	

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hospitals, as shown in Table 4, will result in a
further net increase of 703 active treatment beds
and 119 long-stay or chronic beds.

Table 4
Estimated Increase in Hospital Beds

Hospital	Total Beds Approved by in Existing	No. of Beds to be Added	Net Increase in Capacity
St. Michael's	52	43	19
St. Joseph's	27	14	13
St. Vincent's	138	65	30
St. Elizabeth's	200	105	75
St. Mary's	83	43	40
St. George's	90	28	62
St. James's	34	26	8
St. Andrew's	70	34	36
St. David's	116	62	42
St. William's	25	14	11
St. Michael's	132	74	36
St. George's	52	31	21
St. James's	25	14	11



Additions Planned but not under Construction

<u>Hospital</u>	<u>Total Beds</u>	<u>No. of Beds</u>	<u>Net Increase in</u>	
	<u>Approved by</u>	<u>in Existing</u>	<u>Active</u>	<u>Capacity</u>
	<u>Commission</u>	<u>Hospital</u>		<u>Long-Stay</u>
Saint Joseph's	141	98	19	24
South Cumberland	11	9	2	
Twin Oaks	14	9	5	
Victoria General	850	522	328	
Western Kings Memorial	68	43	25	
	2,188	1,276	793	119

242. If all of these hospitals are constructed as now planned, the total hospital facilities of the Province will reach the figure of 4,878 active and long-stay beds. On the basis of an estimated population of 756,106 in 1965, this would be a ratio of 6.45 beds per thousand. To reach 6.9 beds per thousand, there should be 5,217 beds by 1965, or an additional 339, almost all of this shortage being in long-term or chronic hospital beds.

243. We understand that the relatively small Federal Health Grant for hospital construction in relation to the total beds may not be adequate to provide all the additional facilities listed in Table 4, and the additional long-term hospitals for which no provision has yet been made.

244. It gives the medical profession grave concern when a soundly based plan prepared ten years before the introduction of hospital insurance was not

Approved by
Commission
in Existing
Hospital
Active
Capacity

141	98	19	24
11	9	2	
850	522	358	
68	43	25	
2,138	1,276	793	119

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concern when a soundly based plan prepared ten years before the introduction of hospital insurance was not



implemented before insurance came into effect and it gives us even greater concern that financial stringency may now curtail the plan to which the Government is committed. We feel that the full implementation of the hospital insurance plan should be ensured through adequate financial support from the Federal and Provincial Government. There is still a serious shortage of active treatment beds throughout more than half of the Province. There will still be a deficiency in long-term or chronic hospital facilities even if all of the hospitals now under consideration, are constructed. The institutions listed in Table 4 do not include the Nova Scotia Rehabilitation Centre which is seriously in need of new facilities nor the Halifax Children's Hospital which is the chief paediatric referral centre for the whole Province. Almost all of the additional facilities should be for long-term convalescent hospitals, for early activation and physical medicine departments in the existing active treatment general hospitals, and for rehabilitation facilities throughout the Province, all of which may be grouped under the general title of long-term hospitals.

245. We consider also that there are inadequacies in the mental hospital facilities, which will be discussed in another section. Facilities for the care of tuberculosis patients are adequate, largely because of the great decrease in this disease in recent years.

it gives us even greater concern that financial stringency may now curtail the plan to which the Government is committed. We feel that the full implementation of the hospital insurance plan should be ensured through adequate financial support from the Federal and Provincial Government. There is still a serious shortage of active treatment beds throughout more than half of the Province. There will still be a deficiency in long-term or chronic hospital facilities even if all of the hospitals now under consideration, are constructed. The institutions listed in Table 4 do not include the Nova Scotia Rehabilitation Centre which is seriously in need of new facilities nor the Halifax Children's Hospital which is the chief paediatric referral centre for the whole Province. Almost all of the additional facilities should be for long-term convalescent hospitals, for early admission and physical medicine departments in the existing active treatment general hospitals, and for rehabilitation facilities throughout the Province, all of which may be grouped under the general title of long-term hospitals.

We consider also that there are inadequacies in the mental hospital facilities, which will be discussed in another section. Facilities for the care of tuberculous patients are adequate, largely because of the great decrease in this disease in recent years.



1 246. Facilities for nurses' residences and for
2 nursing schools should be provided in order to
3 ensure the nursing staff necessary to operate the
4 enlarged hospitals.

5 247. Finally, because of the long time required
6 to train doctors, immediate steps should be taken
7 to provide Government assistance for the expansion
8 of medical school facilities. We are concerned that
9 there is a limitation on the enrolment of students
10 in the Faculty of Medicine Dalhousie University
11 because of inadequate facilities in the Basic Science
12 Department. In order to take care of the expanding
13 health needs of the growing population, there will
14 be a need for more physicians in the four Atlantic
15 Provinces. If the medical insurance program is
16 expanded through Government assistance, or even
17 if the present growth of voluntary medical insurance
18 continues, there will need to be an expansion of the
19 University facilities so that more physicians can
20 be trained.

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TERM (g) "THE ESTIMATED COST OF HEALTH SERVICES NOW BEING RENDERED TO CANADIANS WITH PROJECTED COSTS OF ANY CHANGES THAT MAY BE RECOMMENDED FOR THE EXTENSION OF EXISTING PROGRAMS OR FOR ANY NEW PROGRAMS SUGGESTED".

248. Estimated Cost of Health Services. The time available has not allowed collection of complete data under this heading. However, some indication of the magnitude of present and possible health expenditures in the future is obtainable from the following tables.

Present Costs

Table A Reported Expenditure 1960

Provincial Department of Health Including Hospital Insurance Commission and Federal Grants	\$36,000,000.00	
Expenditures by Municipalities	3,030,000.00	
Department of Veterans' Affairs	3,500,000.00	
Drugs	5,500,000.00	
Red Cross Blood Transfusion Service	160,000.00	
	\$48,190,000.00	\$48,190,000.00

Table B Medical Education and Research (Budgeted)

Professional Education	\$ 1,000,000.00	
Faculty of Health Professions	100,000.00	
Research	350,000.00	
	\$ 1,450,000.00	\$ 1,450,000.00

Table C Estimated Costs 1960

Physicians' Services	\$12,000,000.00	
Ambulance Services	500,000.00	
Private Nursing	65,000.00	
Non-insured Health Items and Voluntary Agencies	1,000,000.00	
	\$13,565,000.00	\$13,565,000.00

Table D Unknown Costs

Indian Services	???)	
Immigration and Sick Mariners	???)	
Armed Services Personnel	???)	\$???
Partial Present Costs		\$63,205,000.00

(Estimated Cost of Health Services) Continued on Page 79.

FORM (a) THE ESTIMATED COST OF HEALTH SERVICES NOW BEING RENDERED TO PATIENTS WITH PROTECTED COSTS OF ANY CHARGES THAT MAY BE RECOMMENDED FOR THE EXTENSION OF EXISTING PROGRAMS OF FOR ANY NEW PROGRAMS SUGGESTED.

2. Estimated Cost of Health Services. The time available has not allowed collection of complete data under this heading. However, some indication of the magnitude of present and possible health expenditures in the future is obtainable from the following tables.

Present Costs

Table A. Reported Expenditure 1960

Provincial Department of Health	
Including Hospital Insurance	
Expenditures by municipalities	3,030,000.00
Department of Veterans' Affairs	3,500,000.00
Drugs	2,500,000.00
Red Cross Blood Transfusion Service	100,000.00

Table B. Medical Education and Research (Budgeted)

Professional Education	\$ 1,000,000.00
Faculty of Health Professions	100,000.00
	\$ 1,100,000.00
	\$ 1,450,000.00

Ambulance Services	500,000.00
Private Nursing	65,000.00
and Voluntary Agencies	1,000,000.00

Indian Services	2 2 2
Immigration and Sick Menstrues	2 2 2

Partial Present Costs \$63,205,000.00

Estimated Cost of Health Services (Cont'd.)

249. Hence the total of Medical Health expenditures in Nova Scotia is of the order of \$64,205,000.00 per annum. Since this figure has been obtained from incomplete data, it would be desirable to initiate research to accurately determine health costs in relevant periods and their trends.

250. Estimated Costs of Proposed Additions to Health Services

Table A Capital Items

Medical Education -	-	\$
Expansion of Medical School	\$ 4,500,000.00	
Hospitals		
1. (a) 1170 Active Treatment beds	23,400,000.00	
(b) 919 Convalescent & Chronic beds	9,190,000.00	
2. Rehabilitation Centre	3,000,000.00	
3. Community Health Centres	100,000.00	
4. Medical Health Clinics	150,000.00	
5. Cancer Hostel	100,000.00	
	<hr/>	
	\$40,440,000.00	\$40,440,000.00

Table B Annual Items

Medical Services Insurance through Maritime Medical Care Incorporated to provide comprehensive service based on present plan for 100,000 of population with very low income.	2,500,000.00
Increased Professional Training	1,000,000.00
Para-medical Training	100,000.00
Continuation of Medical Education	150,000.00
Operation of Additional Hospital Accommodation	6,445,000.00
Increased Personnel	3,000,000.00
	<hr/>
	\$13, 195,000.00
	\$13,195,000.00

Table C Unknown Costs: Bursaries,

Financial Assistance to Medical Students	??)	
Financial Assistance to Residents-in-	??)	
training, Financial Assistance to Para-	??)	
medical personnel in training	??)	??
<hr/>		
Partial Estimated Costs of Proposed		
Additions to Health Services		\$53,635,000.00

Hence the total of Medical Health expenditures in Nova Scotia is of the order of \$64,205,000.00

it would be desirable to initiate research to accurately determine health costs in relevant periods and their trends.

250. Estimated Costs of Proposed Additions to Health Services

Table A Capital Items

1. (a) 1170 Active Treatment beds	23,400,000.00
(b) 919 Convalescent & Chronic beds	9,190,000.00
2. Rehabilitation Centre	3,000,000.00
3. Medical Health Clinics	170,000.00
4. Cancer Hostel	100,000.00
	<hr/>
	\$40,440,000.00

Table B Annual Items

Maritime Medical Care Incorporated to provide comprehensive service based on present plan for 100,000 of population with very low income.	2,300,000.00
Increased Professional Training	1,000,000.00
Extra-medical Training	100,000.00
Continuation of Medical Education	150,000.00
Operation of additional Hospital accommodation	6,445,000.00
Increased Personnel	3,000,000.00
	<hr/>
	\$13,195,000.00

Table C

Financial assistance to medical personnel in training	?
Financial assistance to Para-training	?
Financial assistance to Residents-in-training	?
Financial assistance to medical Students	?
Financial assistance to Overseas	?

Partial Estimated Costs of Proposed Additions to Health Services \$13,635,000.00



1 TERM (h) "THE METHODS OF FINANCING HEALTH CARE SERVICES
2 AS PRESENTLY SPONSORED BY MANAGEMENT, LABOR,
3 PREFESSIONAL ASSOCIATION, INSURANCE COMPANIES,
4 OR ANY OTHER MANNER".

5 251. (a) Management. Although certain health services
6 are made available to the employee by management
7 without charge in the event of sudden illness or
8 accident while at work, the majority of health
9 services required by the employee and dependents
10 are provided by a Health Insurance Program. The
11 type of program chosen may be at the sole discretion
12 of management or by joint negotiation between
13 management and the Employee's Association or Union.
14 The amount of financial assistance given by
15 management varies with the type of program chosen.

16 252. Regardless of the program chosen,
17 management usually absorbs the cost of providing
18 for payroll deduction of the required premium and
19 maintaining the related records. Management may
20 also contribute directly toward the cost of the
21 program by paying a portion of the premium. The
22 amount of this contribution varies considerably from
23 company to company and does, in fact, range from
24 nothing to 100% of the premium. Usually management
25 personnel assist in enrolling new employees in the
26 chosen program and keep all participants informed of
27 their entitlement under the plan.

28 253. Where the program selected is of an
29 "indemnity" type, management is often required to
30 assume the indirect cost of making staff available
31 for the completion and submission of claim forms on

TERM (b) "THE METHODS OF FINANCING HEALTH CARE SERVICES
AS PRESENTLY SPONSORED BY MANAGEMENT, LABOR,
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"indemnity" type, management is often required to
assume the indirect cost of making staff available
for the completion and submission of claim forms on



1 behalf of the employee and act in a liaison capacity
2 in case of disputes between the claimant and the
3 underwriter.

4 254. If the program selected is of the "service"
5 type the functions performed by management as
6 outlined in the preceding paragraph are not usually
7 performed. Claims are submitted by the provider of
8 the service directly to the Plan and reimbursement
9 made directly to the provider in an amount
10 previously agreed upon as being "payment in full" for
11 that service. In case of a dispute that plan acts
12 on behalf of the patient and it is rarely that the
13 patient or management become involved.

14 255. There are also health services programs in
15 operation which have been created by management for
16 the sole benefits of its employees and their
17 dependents. In these programs management selects a
18 doctor, hospital or group of doctors and hospitals
19 and negotiates with them for their services with
20 reimbursement based on a flat monthly or annual
21 premium payment per participant regardless of the
22 nature or volume of services the participants require.
23 Although this method has been found in many cases,
24 to reduce the cost of financing a health program for
25 both management and and its employees, it does have
26 definite weaknesses in that (a) the patient is denied
27 a free choice of doctor or hospital. (b) The
28 quality of care sometimes suffers because reimburse-
29 ment is not based on the amount and complexity of
30 services required. (c) The benefits of the program



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are usually confined to those services that can be performed by the group under contract. There a service is required that is beyond the ability of the group retained, the patient may be liable for all or a major portion of the cost.

256. In summary, it can be said that management's financial assistance toward the provision of health services has been an important factor in making insured benefits available to a large segment of the population. Over the years, as management's financial status in health programs has increased, it has demanded a greater voice in the type and level of services that should be made available and this has resulted in more comprehensive programs being offered by the various underwriters.

257. (b) Labor. The outstanding example in Nova Scotia of a medical care plan sponsored and controlled by labor is that of the colliery workers of Cape Breton and other provincial coal areas, the "check-off" system for medical services to workers and their dependents by payroll deductions. This system began in 1883 in some areas. It was approved by provincial legislation in 1903 and enabling legislation was passed in 1918 to have payroll deductions for hospital and physician's services compulsory on written demand to the employer (usually by presentment of the so-called doctor's card signed by the colliery worker at the colliery employment office). No direct employer contribution was required.

258. Initially this system included medical and

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service is required that is beyond the ability of



1 surgical care in the home, office and hospital with
2 the dispensing of most drugs without extra charge.
3 In 1947, the following failure of negotiations
4 between the colliery workers and the physicians to
5 secure an increase in the capitation fee, the
6 dispensing of the drugs was discontinued. However,
7 within two years the colliery workers agreed to pay
8 an increased rate to have the privileges of "drugs
9 without cost" restored to them. Since that time there
10 has been continued difficulty between physicians and
11 workers regarding fees and services and there have
12 been several modifications in the system. At the
13 present time, on the mainland and in one Cape Breton
14 county area (Seaboard Corporation), the workers
15 receive their medical services insurance through a
16 commercial carrier with payroll deductions as before;
17 drug costs are not included. In the North Sydney
18 and New Waterford areas the weekly subscription per
19 worker is now \$1.00 which covers himself and his
20 dependents for home, office and hospital services,
21 including major surgery. Drugs are dispensed by the
22 regular prescription method at the patient's own cost.

259. In the Glace Bay area the fee is \$1.25
23 weekly and nearly all drugs are supplied to the sub-
24 scriber and dependents without cost to him; otherwise,
25 the service rendered is as in the North Sydney and
26 New Waterford area. However, the physicians in the
27 Glace Bay area have recently notified their sub-
28 scribers that the dispensing of drugs would be
29 discontinued and have encouraged their subscribers
30

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1 that, if they are not satisfied with this, the
2 "check-off" be abandoned in favor of a service plan.
3 Indeed, in 1926 the Royal Commission on the Coal
4 Mining Industry in Nova Scotia had recommended that
5 the "check-off" system be abandoned.

6 260. The "check-off" to doctor and hospital was
7 a condition of employment by the major coal mining
8 operator and others, until after the MacKinnon
9 Commission findings (1959) were announced. Up to
10 this date the man's own physician cared for the
11 injured miner without remuneration by the Workman's
12 Compensation Board as part of the "check-off" service
13 and not as employee of the Company. More recently
14 the major operator has abandoned the "check-off"
15 condition of employment and the injured are now cared
16 for by their own physician with remuneration by the
17 Workman's Compensation Board on a fee-for-service
18 basis.

19 261. It might be noted that, although "check-off"
20 is not longer a condition for employment, only a few
21 employees in the Glace Bay area have taken advantage
22 of this. It is also to be noted that the dispensing
23 of drugs by physicians as practised in the colliery
24 areas, is contrary to the policies of the Canadian
25 Medical Association, but has been tolerated because
26 of its long accepted established custom. The Nova
27 Scotia Pharmaceutical Society has also tolerated it
28 without loud protest probably for the same reason.

29 262. The "check-off" system represents one of the
30 few Canadian examples of the application of the

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The "check-off" system represents one of the
few Canadian examples of the application of the

capitation fee to finance medical services. Its advantages may be summarized as the provision of a system of prepaid medical care at very low rates and a simplified system of administration. Its disadvantages are that it severely limits choice of doctor, promotes superficial attention, over-emphasizes the use of drugs, inhibits the entry of new doctors into practice, impairs the doctor-patient relationship, and provides a large volume of services increasinsly difficult to maintain above a mediocre level. Despite eighty years of existence, its disadvantages (which include an apparent increasing dissatisfaction of the subscribers themselves) so greatly outweigh its advantages that physicians practising under this plan believe it should be abandoned.

263. (c) Professional Associations. Due to the inadequacies in health insurance plans being offered to the public in Canada, hospital and doctor sponsored programs were created with a view providing comprehensive programs to the citizens of Canada on a non-profit basis.

264. Because of the regional variations of need and economic factors, these programs were designed on a provincial basis and sponsored by the provincial Medical Associations.

265. As "providers" of the services, the medical profession created medical care plans which they felt best suited the patients in their area. The "indemnity" approach was considered by them as

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1 inadequate, with the result that the "service" type
2 of program was introduced. Under this arrangement,
3 the practising doctor agreed to accept as payment in
4 full for his service that fee agreed upon between the
5 plan and the doctors' Provincial Medical Society.
6 At general practitioner level it was agreed that the
7 patient would not be billed for an additional amount.
8 Many plans included arrangements with specialists
9 for no extra billing and in some cases the plans
10 and specialists agreed to a "controlled" amount of
11 billing for a specific specialist service. The
12 medical profession in many provinces, also agreed to
13 underwrite the losses of the plan should income from
14 premiums fail to meet the costs of services received
15 by members by accepting a lesser fee during such a
16 period of crisis.

17 266. From the point of view of the public, the
18 doctor sponsored "service" program is a highly
19 satisfactory method of providing health insurance
20 as is indicated by the spectacular growth of the
21 plans since they were first introduced. In most
22 provinces the doctor sponsored program is by far the
23 largest underwriter of medical care in that area.

24 267. Its appeal to the public and profession
25 alike can be attributed to the fact that doctor and
26 patient are free to treat and be treated with a
27 minimum of "third party" interference. The patient
28 selects his doctor, presents his membership card,
29 receives all necessary care and the doctor in turn
30 submits his account to the plan for reimbursement on

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Its appeal to the public and profession alike can be attributed to the fact that doctor and patient are free to treat and be treated with a minimum of "third party" interference. The patient selects his doctor, presents his membership card, receives all necessary care and the doctor in turn submits his account to the plan for reimbursement on



1 the basis of fees agreed to and usually set by his
2 provincial association.

3 268. Both management and employees have supported
4 this type of program as being the one most closely
5 meeting the public's total medical care need of
6 any program yet designed.

7 269. The financing of the doctor sponsored
8 program is done in many ways. Sometimes the program
9 is paid for, all or in part, by the employer or the
10 subscriber. Some programs for indigents are
11 receiving provincial or municipal government
12 assistance. Also in all programs offered by the
13 plan the medical practitioner agrees to participate
14 in the cost as provided for in his agreement with
15 the plan by underwriting all or a portion during
16 adverse risk periods.

17 270. (d) Insurance Companies. There are a wide variety
18 of insurance companies operating in the health
19 insurance field. Some confine their activities to
20 health and accident coverage only, whereas others
21 offer this type of insurance only as part of a
22 complete line of which life and weekly indemnity
23 insurance receive their major effort. Whether they
24 are mutual companies or are organized for profit,
25 the "indemnity" approach to health insurance is
26 generally used. Under this method the underwriter
27 usually agrees to pay a specific dollar amount for a
28 given health service regardless of who performed the
29 service, or where in Canada, it was performed. In
30 some companies, the level of payment may vary, subject

the basis of fees agreed to and usually set by him

Both management and employees have supported

this type of program as being the one most closely

meeting the public's total medical care need of

any program yet designed.

The financing of the doctor sponsored

program is done in many ways. Sometimes the program

is paid for, all or in part, by the employer or the

subscriber. Some programs for indigents are

assistance. Also in all programs offered by the

plan the medical practitioner agrees to participate

in the cost as provided for in his agreement with

the plan by underwriting all or a portion during

adverse risk periods.

(d) Insurance Companies. There are a wide variety

of insurance companies operating in the health

insurance field. Some confine their activities to

health and accident coverage only, whereas others

offer this type of insurance only as part of a

complete line of which life and weekly indemnity

insurance receive their major effort. Whether they

are mutual companies or are organized for profit,

the "indemnity" approach to health insurance is

usually agreed to pay a specific dollar amount for a

given health service regardless of who performed the

service, or where in Canada, it was performed. In

some companies, the level of payment may vary, subject



1 to the wishes of the company buying the coverage.

2 271. Some rational employers argue that the
3 indemnity approach fixes a uniform settlement for a
4 given service to all of its employees regardless of
5 their location in Canada, and is therefore fair to
6 all participants. Because of varying economic levels
7 across Canada, the cost of these services must of
8 necessity vary with the result that in one province
9 an employee may receive more, and as a result,
10 profit from being sick, whereas an employee in
11 another area may be required to supplement the
12 "indemnity" payment from his earnings.

13 272. Quite often the level of benefits offered
14 vary considerably with what would appear to be little
15 logical reasoning, resulting in dissatisfaction to
16 both patient and doctor. For example, it is not
17 uncommon under commercial insurance plans, to provide
18 a fee for surgery, but no fee for the surgical
19 assistant and/or anaesthetist, both of which services
20 are usually required. Coverage for medical service
21 is frequently omitted. Service benefits as offered
22 by the medically sponsored non-profit plans have
23 avoided this shortcoming by keeping its benefits as
24 comprehensive as possible. This is achieved by
25 close liaison between the plan and its sponsors so as
26 to broaden the benefits in keeping with the ever
27 changing needs of the public.

28 273. Insurance companies generally speaking,
29 usually prefer, and often confine their sales to
30 group business which tends to give a preferred age



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category. The "self employed" or an individual, is usually unable to obtain a suitable program for his health insurance requirements from the commercial carrier.

274. A further disadvantage to the commercial program is that quite often benefits are considerably reduced or eliminated when an employee terminates with his employer by retirement, or for any other reason. This practice quite often denies coverage when it is most needed and when it is difficult to obtain it from another underwriter. The doctor sponsored plans attempt to continue members on the same or comparable coverage when leaving a group.

275. Indemnity plans as offered by commercial insurance companies do not always meet the total cost of needed health services and in many cases the programs are designed so that the total cost will not be covered by the Company. This is frequently achieved by inserting "deductible" and "co-insurance" clauses. As an example, a policy may not cover the first \$50.00 of expense and only 75% or 80% of expenses incurred above the deductible amount. Termination of contracts, under certain conditions, frequently occurs.

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1 TERM (i) "THE METHODS OF FINANCING ANY NEW OR INTENDED
2 PROGRAMS WHICH MAY BE RECOMMENDED".

3 276. The recommendations contained in this
4 submission inevitably point to the necessity of
5 providing public funds in substantial amounts to
6 promote the improvement of health services. We are
7 aware that in many provinces, including Nova Scotia,
8 governments are hard pressed to meet their current
9 commitments. In some instances the limit of taxation
10 appears to have been reached and we feel that
11 adjustments in federal-provincial fiscal relation-
12 ships may be required to finance new commitments.
13 Among the major recommendations which will involve
14 public financing are:

15 Aid to medical education.

16 Increased hospital facilities of all types.

17 The reform of mental health services.

18 The promotion of rehabilitative services.

19 277. The extension of Cancer control measures,
20 and several of our new and developing services will
21 require such financing. We have carefully considered
22 whether such services could be financed by the
23 contributions of beneficiaries, but it is our view
24 that collective approach is warranted.

25 278. Methods of Raising the Funds. The Society limits
26 itself to the observation that if the Health Care
27 Program is to be financed out of general revenue,
28 then safeguards must be established to prevent the
29 program becoming fixed or limited by subordination
30 to the financial demands of other departments of
government. This could be a very real danger is

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illustrated by the suggested curtailment of expenditure for Hospital Services Insurance. It is our view that a Health Care Program can best be administered and financed by an autonomous fiscal arrangement.

279. In the case of medical services insurance, our experience leads us to recommend a modification which combines public and private expenditures in a co-operative effort to make such services available to all. The following analysis of the situation spells out our views in considerable detail.

280. Methods of Disbursement. The classical modes of payment for physicians' services are (1) fee for service, (2) subsidization, i.e. part salary and part fee for service, (3) salary, (4) capitation.

281. The Medical Society of Nova Scotia recognizes that no one method of remuneration can be adopted to the exclusion of others. The Society realizes that recompense by salaries is probably the best method of payment for physicians engaged full time in public service, in university work, in research, in administration and perhaps for those concerned with lengthy procedures where a team of doctors is required. Moreover, there are areas of the Province where the population is thinly scattered and where income is too low to support a physician, where subsidization may be required. In Nova Scotia it is estimated that about one hundred (100) physicians now receive 80% or more of their incomes other than straight fee for service.

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1 282. The Society is opposed to the capitation
2 system of payment for physician services. It sees
3 this system as fostering a great unevenness of the
4 work load, and an over utilization of the physicians'
5 services, resulting in wastage of his energy and his
6 talents through involvement in minor matters to the
7 detriment of the quality of his services. It leads
8 to a lessened time for leisure, study, and
9 contemplation that are so necessary to a doctor's
10 continuing development.

11 283. In the view of the Medical Society, the fee
12 for service method of payment to physicians medical
13 service is the most flexible and equitable. It
14 allows for a financial return that is proportionate
15 to the responsibility. It permits remuneration
16 commensurate with the level of training of the
17 individual physician, and with the difficulty of the
18 procedure. It best preserves the doctor-patient
19 relationship. It minimizes the dangers of third
20 party control over and interference with the purely
21 medical aspects of the provision of physician
22 services.

23 284. The principle of fee for service has been
24 tested not only by its having been historically the
25 principal method of payment for physician services
26 in Canada, but by its success in medical services
27 insurance, both non-profit and commercial. Realizing
28 the need for a type of medical care program which
29 would provide the residents of Nova Scotia with a
30 high standard of medical care at reasonable cost,

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1 the medical profession of the Province created
2 Maritime Medical Care Incorporated. The Corporation
3 was set up by a special Act of the Legislature of
4 the Province on April 29th, 1948. (Appendix VIII).

5 285. The success of this professionally
6 sponsored plan of medical services insurance leads
7 us to the conclusion that this is the method of
8 coverage that is most adaptable to Canadian
9 circumstances.

10 286. The non-profit plan has these attributes:

11 (1) It reduces third party control to a
12 minimum and so preserves the doctor-patient
13 relationship with a minimum of interference.

14 287. (2) It allows those able to pay the premium
15 the opportunity to do so voluntarily. These are
16 convincing reasons in terms of psychology of patient
17 and physician for services to be paid for in this
18 way.

19 288. "My doctor" and "my patient" are of deep
20 significance. The patient who makes some financial
21 effort to provide for himself a service that he
22 values is exceedingly co-operative. The doctor
23 himself is not unaffected. Some who, at appropriate
24 times for their purposes, praise the medical
25 profession, will say that this is not so, and that a
26 medical man with all his fine qualities would not be
27 motivated by such worldly considerations. He would
28 give the same service whether he were paid directly
29 by the patient or not. In a serious illness of life
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1 situations, where the patients' complaints are
2 psychological, is equally true. It is interesting
3 to note that the same people who loudly proclaim the
4 virtues of the physician at the former point, are
5 the ones that most commonly support the view that he
6 cannot be paid on a fee for service basis because
7 under this mode of payment his virtue will break
8 down. It would be more realistic to consider doctors
9 as being human and having faults that will make some
10 difficulties under any plan, and that these will be
11 least under a fee for service system, where the
12 quality of medical care can remain high.

13 289. If on the other hand a compulsory,
14 universal system of medical services insurance were
15 to be adopted, then the people of Canada, who will
16 be recipients of the service, and who will also
17 underwrite the cost, must be encouraged to recognize
18 that Medical Services Insurance is primarily a method
19 of purchasing certain services through government.
20 The traditional form of the practice of medicine
21 involves a private understanding between patient and
22 physician. The individual arranges for the service
23 and is himself responsible for payment. The
24 interposition of third parties, who administer the
25 funds collected in advance from large numbers of
26 persons to spread the burden of the cost of illness,
27 has blurred this essential element of responsibility
28 for payment, but has not removed it. If quality
29 medical services are to be provided in the future,
30 regardless of the individual's ability to pay, then



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each citizen must know that if Peter does not pay for the services he has received, then Paul must add part of Peter's cost to his own.

290. (3) But for those who cannot afford the full premium, or cannot afford any contribution to a premium, the professionally sponsored non-profit prepaid medical insurance plan allows for the contribution to the premium in whole or in part by the employer or by government. The agreement between the Department of Public Welfare of the Province of Nova Scotia and the Nova Scotia Medical Society is an example of the smooth working of this principle. More recently a request from the Federal Department of Indian Affairs for the submission of a plan for the medical coverage of the Indians in Nova Scotia, is a further example of interest and possible further participation in such plans.

291. Two arguments have been voiced against this partial or complete payment of a premium by government.

(a) It has been stated that it would amount to subsidization of an existing system.

(b) That there would be required a means test.

292. Since subsidization to the provinces, to industry, transportation, agriculture and mining are political and economic realities, the objection cannot be to subsidization in itself. The objection must be then to the existing system of doctor-patient relationships and their freedoms that are the



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1 hallmarks of the private practice of medicine. It
2 is note-worthy that this objection is linked with
3 the advocacy of salaries, control of physicians and
4 their geographic distribution. In short, the civil
5 conscription of a profession.

6 293. We recognize that there is a significant
7 segment of our population who will not be able to
8 pay for basic comprehensive coverage under Medical
9 Services Insurance. Since their ranks are not
10 constant, these people should be registered as they
11 enter or leave the pool as "having financial
12 difficulties" or "complete inability to pay". It is
13 preferable that these persons report themselves, but
14 their numbers must be known before the cost of a
15 health service can be estimated. This figure is one
16 measure of health needs.

17 294. In Nova Scotia those who are recipients of
18 Welfare Benefits (old age assistance, disability
19 and blindness benefits, or social assistance),
20 number 11,754. Receiving financial assistance from
21 the Municipalities are another 89,289 persons, the
22 two totalling 101,043. From these figures, it can
23 be seen that 101,043 persons require a full
24 contribution by government for their basic
25 comprehensive coverage under Medical Services
26 Insurance.

27 295. In addition to these easily identifiable
28 citizens with low incomes, there is probably an
29 economic stratum where some financial assistance to
30 purchase medical services insurance will be required.

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1 296. We further recognize that many persons by
2 reason of pre-existing disability or age, may require
3 financial assistance to provide the comprehensive
4 coverage which they need.

5 297. The first group is already defined. It is
6 equally proper that the second group be identified,
7 and we stand ready to co-operate in the effort.

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1 TERM (j): "THE RELATIONSHIP OF EXISTING AND ANY
2 RECOMMENDED HEALTH CARE PROGRAMS WITH MEDICAL
3 RESEARCH AND THE MEANS OF ENCOURAGING A HIGH
4 RATE OF SCIENTIFIC DEVELOPMENT IN THE FIELD
5 OF MEDICINE IN CANADA".

6 298. Medical knowledge has grown at an
7 unprecedented rate during the past twenty years. It
8 is vitally important that future health programs in
9 Canada should not stifle this rapid progress but
10 should be designed specifically with a view to
11 encouraging basic research and clinical investigation.
12 To achieve this end requires very careful planning
13 of physical facilities, financial policies and
14 administrative procedures.

15 299. It would be over-optimistic to assume that
16 an increase in Government expenditure for health
17 services would automatically result in an improvement
18 of medical knowledge.

19 300. In this Province there is already a danger
20 sign in the suggestion by some persons that medical
21 research should be the responsibility of the Medical
22 School only, and that the costs of clinical
23 investigation are not a valid charge under the
24 hospital insurance plan. We believe that a qualified
25 physician with a bent toward research should not
26 only be permitted, but encouraged to carry out
27 investigations within his competence. Even in
28 smaller hospitals the general practitioner or
29 specialist should be able to explore new ideas for
30 the diagnosis and treatment of disease. It is even
more important to recognize that any larger hospital,
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1 training, is in fact an educational institution as
2 well as a treatment centre. Post-graduate education
3 of an adequate quality cannot be given unless the
4 staff and specialists-in-training have opportunities
5 for clinical investigation. The necessary
6 laboratory facilities for such clinical investigation
7 units are an integral part of a teaching hospital
8 even in a centre where there is no Medical School.

9 301. We recognize as well that much basic and
10 applied medical research will continue to flow from
11 the Medical Schools, but to limit it to them would
12 stifle much practical research which can only be done
13 in hospitals.

14 302. Canada is not spending proportionately as
15 much on medical research as Britain or the U. S. A.
16 Most of the available money goes toward the support
17 of research in the basic medical sciences. More
18 money is required for clinical research and public
19 health research and for laboratories and clinical
20 investigation units in which such work can be done.
21 The expenditure of more money in this direction as
22 well as in the extension of research facilities in
23 Medical Schools would, we believe, reap large
24 rewards.

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TERM (k) "THE FEASIBILITY AND DESIRABILITY OF PRIORITIES
IN THE DEVELOPMENT OF HEALTH CARE SERVICES"

303. We are convinced of both the feasibility and the desirability of priorities in the development of health care services. Throughout the discussion in this submission there has recurred the theme of deficiencies in facilities for diagnosis and treatment; deficiencies in service in special fields, in training of professional and para-medical personnel and the provision of comprehensive medical insurance coverage for those of low income.

304. Medical Personnel. The time lag in years that occurs from the beginning of training to the attainment of productive work forces us to the conclusion that the first priority must be increased efforts of recruitment of medical students to increase the number of general practitioners. An increase in the number of physicians trained in each specialty is required. One approach to this might be a review, extension and modification of the terms on which are based existing training grants. This priority involves as well as the development of teachers of medicine and the necessary expansion of the facilities of the medical school to cope with an increased enrolment of medical undergraduates and post-graduate students to keep abreast with advances in medical science. Programs for the continuing post-graduate education of the practitioner designed to include professional and public recognition as well as financial security during his training are essential.

IN THE DEVELOPMENT OF HEALTH CARE SERVICES

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1 305. Facilities and Para-medical Personnel. As the
2 second priority requiring concurrent action with
3 the first, we would put the necessity of correcting
4 the unmet needs in beds, facilities and services.
5 Without this improvement as an initial endeavor,
6 the quality of medical care will be affected
7 adversely. The projected expansion of the general
8 hospitals in Nova Scotia by 1,401 additional beds
9 over the 1956 total will do much to solve the
10 problems of active hospital treatment, the provision
11 of physiotherapy and occupational therapy departments,
12 of sub-depot laboratories in the regional hospitals,
13 will be a welcome addition to health care facilities.
14 However, there are needed additional beds for the care
15 of the convalescent patient, the chronically ill and
16 for the domiciliary care of the aged.

17 306. New quarters for the Nova Scotia
18 Rehabilitation Centre are urgently required.
19 Consideration could well be given to the establish-
20 ment of additional rehabilitation centres in other
21 dense areas of population in the Province and to the
22 provision of community health centres. Of equal
23 importance with the need to expand the physical
24 facilities, is the need to further develop services
25 already in existence and to train and provide the
26 personnel to operate them.

27 307. The mentally ill occupy half of the total
28 beds in this Province. Any program that will help
29 to alleviate this situation has high ascendancy. We
30 believe that great improvements in mental health



the first, we would put the necessity of correcting the most needs in beds, facilities and services. Without this improvement as an initial endeavor, the quality of medical care will be affected adversely. The projected expansion of the general hospitals in Nova Scotia by 1,401 additional beds over the 1956 total will do much to solve the problems of active hospital treatment, the provision of physiotherapy and occupational therapy departments, of sub-depot laboratories in the regional hospitals, will be a welcome addition to health care facilities. However, there are needed additional beds for the care of the convalescent patient, the chronically ill and for the domiciliary care of the aged.

New quarters for the Nova Scotia

Consideration could well be given to the establishment of additional rehabilitation centres in other dense areas of population in the Province and to the provision of community health centres. Of equal importance with the need to expand the physical facilities, is the need to further develop services already in existence and to train and provide the personnel to operate them.

The mentally ill occupy half of the total beds in this Province. Any program that will help to alleviate this situation has high priority. We believe that great improvements in mental health

306.



care can be brought about by the decentralization of treatment to small local hospitals and in mental health clinics with the aid of social and vocational guidance. The cost of drugs for the mentally disturbed, the arthritic and the patient with malignancy should be met in a fashion similar to that for the diabetic.

308. The deficiencies in the facilities for training para-medical personnel and their numbers, have been dealt with. The shortage of nurses, nursing assistants, orderlies, laboratory and X-ray technicians, physio and occupational therapists, medical record librarians and social workers is such as to be a major impediment in the provision of high quality health care. The career opportunities in these fields must continue to be attractive so that a recruitment effort directed to the emotionally mature and bright youth can be productive.

309. Comprehensive Medical Service Insurance. As the third priority, we would put the voluntary, comprehensive medical insurance coverage of all citizens in Nova Scotia. We stress that this coverage should be voluntary for those citizens of the Province who are able to pay for their medical care directly or able to pay the premium required for coverage. Those regarded as being financially incapable of meeting fully major health expenses will require a contribution of the premium in whole or in part by the employer or by government. We estimate that approximately 100,000 of the population in Nova

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incapable of meeting fully major health expenses will

require a contribution of the premium in whole or in

part by the employer or by government. We estimate

that approximately 100,000 of the population in Nova

Scotia receive welfare assistance in some form.

These we consider as financially incapable to meet expenses of health services. They will require payment of their premiums in full.

310. As the fourth priority we would encourage decentralization of medical services. Studies now proceeding will indicate certain geographical areas in Nova Scotia with scattered population and relatively low income which require medical services. In such identified areas it will be necessary to attract general practitioners. We believe that the development of Community Health Centres, will be advantageous with or without subsidization of the physician by government.

311. Specialist services in Nova Scotia are, in general, restricted to populated areas. We would endorse subsidization to provide such specialist services where indicated. This principle would also permit the specialist to devote time to wider public service in such areas.

312. Throughout the realm of health services there are established or developing programs sponsored by voluntary agencies with or without government assistance. We believe each should be examined to attempt to ascertain the present and potential effectiveness.



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APPENDIX I

THE CANADIAN MEDICAL ASSOCIATION
STATEMENT OF MEDICAL SERVICES INSURANCE (i)

The Canadian Medical Association believes that:

The highest standard of medical services should be available to every resident of Canada.

Insurance to prepay the costs of medical services should be available to all regardless of age, state of health or financial status.

Certain individuals require assistance to pay medical services insurance costs.

The efforts of organized medicine, governments and all other interested bodies should be coordinated towards these ends.

While there are certain aspects of medical services in which tax-supported programs are necessary, a tax-supported comprehensive program, compulsory for all, is neither necessary nor desirable.

The Canadian Medical Association will support any program of medical services insurance which adheres to the following principles:

1. That all persons rendering services are legally qualified physicians and surgeons.
2. That every resident of Canada is free to select his

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That all persons rendering services are legally

qualified physicians and surgeons.

That every resident of Canada is free to select his



1 doctor and that each doctor is free to choose his
2 patients.

3 3. That the competence and ability of any doctor is
4 determined only by professional self-government.

5 4. That within his competence, each physician has the
6 privilege to treat his patients in and out of hospital.

7 5. That each individual physician is free to select the
8 type and location of his patients.

9 6. That each patient has the right to have all
10 information pertaining to his medical condition
11 kept confidential except where the public interest
12 is paramount.

13 7. That the duty of the physician to his individual
14 patient takes precedence over his obligations to
15 any medical services insurance programs.

16 8. That every resident of Canada, whether a recipient
17 or provider of services, has the right of recourse
18 to the courts in all disputes.

19 9. That medical services insurance programs do not in
20 any way preclude the private practice of medicine.

21 10. That medical research, undergraduate and post-
22 graduate teaching are not inhibited by any medical
23 services insurance program.

24 11. That the administration and finances of medical
25 services insurance programs are completely separate
26 from other programs, and that any Board, Commission
27 or Agency set up to administer any medical services
28 insurance program has fiscal authority and autonomy.

29 12. That the composite opinion of the appropriate body
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1 medical profession adequately represented by any
2 Board, Commission of Agency set to plan, to
3 establish policy or to direct administration for any
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5 13. That members of the medical profession, as the
6 providers of medical services, have the right to
7 determine the method of their remuneration.

8 14. That the amount of remuneration is a matter for
9 negotiation between the physician and his patient,
10 or those acting on their behalf; and, that all
11 medical services programs make provision for
12 periodic or automatic changes in remuneration to
13 reflect changes in economic conditions.

14 (i) Annual Meeting Canadian Medical Association - 1960.



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APPENDIX 2

THE MEDICAL SOCIETY OF NOVA SCOTIA

(Nova Scotia Division of the Canadian Medical Association)

OBJECTS

1. The promotion of health and the prevention of disease.
2. The improvement of medical services however rendered.
3. The maintenance of the integrity and honour of the medical profession.
4. The performance of such other lawful things as are incidental or conducive to the welfare of the public and of the medical and allied professions.
5. The promotion of harmony and unity of purpose between the medical profession and the various bodies assuming economic responsibility for the care of sick or injured persons.

COMMITTEES OF THE MEDICAL SOCIETY OF NOVA SCOTIA

The work of the Society is conducted through committees, of which there are 21 Standing and 9 Special Committees. Excluding those having to do with internal management, the following portray the spheres of activity of the Society in relation to medical services.

Standing Committees

Cancer
Child Health
Civil Disaster
Discipline
Editorial Board (N. S.
Medical Bulletin
Fees
Health Insurance
Legislation & Ethics

Special Committees

Federal Health Grants
Prepaid Medical Plan for
the Atlantic Provinces
Special Research
Specialist Register
Workmen's Compensation
Board Liaison Committee

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Prepaid Medical Plan for the Atlantic Provinces
Medical Research
Specialist Services
Medical Education
Public Health Services



Cont'd.

Standing Committees

Special Committees

Maternal & Perinatal Health
Medical Economics
Nutrition
Pharmacy
Post-Graduate Education
Public Health
Public Relations
Rehabilitation
Traffic Accidents

The Executive Committee meets regularly four to five times in the interval between annual meetings and may call special meetings. Any committee may report to any regular meeting of the Executive and must report to the annual meeting.

There are nine Branch Societies in Nova Scotia which meet at stated times, prior to meetings of the Executive Committee.

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APPENDIX III

SPECIAL RESEARCH COMMITTEE

The Medical Society of Nova Scotia.

Terms of Reference

(Approved by Executive Committee October 1960)

1. "That the Committee formulate a plan or plans which will make available to all people of Nova Scotia an adequate medical care service of high quality.

2. That the Committee carry out such studies and investigations as may be necessary in the formulation of such a plan. Such studies will include the following, but may also encompass any relevant matters necessary to fulfill the purpose stated above:-

(a) a consideration of the present methods of financing and providing medical care in Nova Scotia.

(b) a study of medical and para-medical resources, present and projected.

(c) an estimate of the major un-met medical needs.

(d) an evaluation of the factors responsible for such un-met needs.

(e) a determination of the effectiveness of existing medical insurance plans, whether voluntary non-profit, commercial or Governmental, with respect to the extent of coverage for the

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1 insured individual and the extent of coverage of
2 the population.

3 (f) an evaluation of the strengths and
4 deficiencies of voluntary prepaid, commercial and
5 Government-financed care plans in other areas of
6 the world.

7 (g) a consideration of the effect of such
8 plan or plans on medical education and research.

9 (h) a consideration of the practical means
10 of implementing the Canadian Medical Association
11 statement of policy.

12 (i) a consideration of the extent to which
13 financial assistance from Government might be
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15 for the population."
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APPENDIX IV.

A BRIEF HISTORY OF THE PROVINCIAL MEDICAL BOARD
OF NOVA SCOTIA

Legislation bearing upon medical education and licensure of qualified practitioners of medicine in Nova Scotia dates from May 29th, 1828, when the House of Assembly passed "An Act to Exclude Ignorant and Unskillful Persons from the Practice of Physic and Surgery" (9 George IV, Cap.5). The title of this denotes its significance. On March 30th, 1829 an amending Act (10 George IV, Cap. 10) was passed removing the application of the Act of the preceding year from practitioners who had been resident and in practice in the Province for seven years before it was passed.

The next Act was passed on March 17th, 1847 (10 Vict. Cap 21). This was in essence a consolidation of the Acts of 1828 and 1829.

In 1851 (Rev. Stat. first series) there is a reference to "Regulations Concerning the Practice of Physic and Surgery" but no actual change in legislation.

In 1858 (Chap. 18, R. S. N. S.) "An Act to Regulate the Practice of Physic and Surgery" was passed, repealing former legislation and now providing for (a) registration with the Provincial Secretary, (b) persons so registered could recover fees, (c) physicians practicing in the Province before 1822, entitled to a license without examination, (d) Provincial medical appointments to be held only by physicians duly registered, (e) certificates of registration to be received in

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evidence, and, (f) a penalty of five pounds for failing to register.

Chapters 57, R. S. N. S. 1858 and Chapter 56 R. S. N. S. 1864 did not make any essential changes.

This was the situation when on April 18th, 1872, Chapter 31 (R. S. N. S.) "An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery" passed the Legislature. Under it the Provincial Medical Board was created, consisting of nine members, five appointed by the Governor in Council and four by the Medical Society of Nova Scotia. Provision was made for a Medical Register and its annual publication. A course of study prerequisite to examination was required and examiners for candidates seeding the license, provided. Registration was made compulsory and a penalty of \$20.00 a day set for those who practiced without registration.

In 1873 (Chap. 28, R. S. N. S.) The Medical Act appears unchanged. In 1877, 1880 and in 1881 minor amendments were made.

In 1884 (Chap. 24, R. S. N. S.) the membership of the Board was increase from nine to thirteen, in the relation of seven to six, appointed on the same basis as the original Board. Powers of the Board were increased and so was the registration fee.

In 1886, 1889 and 1891 slight changes were made by Act or Order in Council dealing with preliminary education of medical students and the medical curriculum.

Anticipating by many years the Canada Medical Act and the inter-provincial reciprocity granted by the

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4 covered by an Order-in-Council dated September 13th, 1895.
5 Later Manitoba joined the Maritime Province Group as did
6 Quebec for a time, the latter withdrawing later.

7 For purposes of record the Board appointed by
8 the Act of 1872 consisted of the following:

9 By the Governor-in-Council:

10 Dr. R. S. Black, Halifax
11 Dr. C. J. Farrish, Yarmouth
12 Dr. Edward Farrell, Halifax
13 Dr. W. H. Macdonald, Antigonish
14 Dr. S. M. Weeks, Newport

15 By the Medical Society of Nova Scotia:

16 Dr. W. J. Almon, Halifax
17 Dr. C. C. Hamilton, Canard
18 Dr. S. Muir, Truro
19 Dr. D. McN. Parker, Halifax

20 The first meeting was held in Province House,
21 July 24th, 1872. The first President was Dr. Hamilton,
22 Dr. R. S. Black, Treasurer and Dr. W. J. Almon, Registrar
23 and Secretary. The first Medical Register was published
24 in the Royal Gazette, August 1873.

25 From the foregoing it will be seen that the
26 medical profession in Nova Scotia followed two important
27 highways, parallel but often linking.

28 The Medical Society of Nova Scotia looked after
29 the needs of the duly qualified registered practitioner.
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1 of members are appointed by the Government has dealt with
2 problems of education and licensure, as well as the
3 discipline of its registrants.

4 Each has supported the hands of the other in
5 maintaining high standards of professional qualification
6 for licensure, and adequate and ethical standards of
7 practice.

8 The organized teaching of medicine has gone on
9 in Halifax since 1868. Carried on first by Dalhousie
10 then by the Halifax Medical College in affiliation with
11 Dalhousie and since 1911 by Dalhousie once more. It has
12 received continuous and strong support academically from
13 the Provincial Medical Board. Mutual interests in
14 creating and continuing high standards for professional
15 qualification have resulted in continuous and meaningful
16 co-operation throughout the years.

17 With reference to detail, legislation related
18 to the practice of medicine as contained in the Medical
19 Act has proceeded on the following lines:

- 20 (1) Implementation of the Canada Medical Act
21 in recognition of the reciprocal qualific-
22 ation issued following examination by the
23 Medical Council of Canada.
- 24 (2) Regular improvement of standards for
25 admission to a course of study in medicine
26 and of the subject matter of the course
27 leading to the admission of a candidate
28 to the examination for a license to
29 practice in this Province.
- 30 (3) Clearer definitions of what constitutes
the practice of medicine to the exclusion
of unqualified persons, in the public
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- (4) Supporting efforts of undergraduate and
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APPENDIX V.

COMMUNITY MEDICAL MANPOWER QUESTIONNAIRE
SPECIAL RESEARCH COMMITTEE
THE MEDICAL SOCIETY OF NOVA SCOTIA, AUGUST, 1961

1. Name of Community -----
2. Number of Physicians in this Community -----
3. Type of Practice:

	Name	Residence	(1) General Practice	(2) Specialty Practice Identify Specialty	(3) General Practice with major Interest in:-	(4) Certification of Fellowship in:-	(5) Recognized as Specialist without (4) yes no	(6) Others - such as Public Health Industrial Hygiene Retired, etc.
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								



Community Medical Manpower Questionnaire (Cont'd.) (2)

4. Approximate population of your community -----
5. Approximate surrounding area served by the Physicians in your community?
- (a) Length and breadth or radius in miles-----
- (b) population in that area -----
6. (a) Do you have hospital facilities in your community? Yes----- No -----
- (b) If not what is the distance to the hospital or hospitals to which patients are sent?
- Please name hospitals 1. ----- Distance 1.-----
2. ----- 2.-----
3. ----- 3.-----
7. (a) Are the doctors in your community on the active staff of these hospitals? Yes ----- No -----
- (b) If not on active staff what arrangements are made for medical attention of patients in hospital? -----
-
- (c) Are emergencies admitted promptly? Yes ----- No -----
- (d) Is there a waiting period for other patients? Yes ----- No ----- If "yes" what is the average delay? -----
8. (a) What is the approximate average number of (1) families ----- (2) individuals ----- served in your community per practising physician?
- (b) In the surrounding area? (1) families ----- (2) individuals -----

in your community per practicing physicians?

(a) What is the approximate average number of (1) families ----- (2) individuals ----- served

(d) Is there a waiting period for other patients? Yes ----- No ----- If "yes," what is the

(f) If not on active staff what arrangements are made for medical attention of patients in hospital? -----

(e) Are the doctors in your community on the active staff of these hospitals? Yes ----- No -----

3. -----

5. -----

Please name hospitals 1. ----- Distance 10. -----

(f) If not what is the distance to the hospital or hospitals to which patients are sent?

c. -----

Approximate surrounding area served by the physicians in your community?

1. -----



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Community Medical Manpower Questionnaire (Con't.) (3)

The following questions are optional to answer, but your opinion will assist us.

9. In your opinion what are the unmet medical needs in (a) your community (b) the surrounding area -----

Please consider the following:

1. Family physicians services -----

2. Consultant medical services - in what specialties? -----

3. Diagnostic services -----

4. Treatment services - drugs, clinic, illness, nursing, etc. -----

5. Rehabilitation services -----

6. Others -----

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Others

2. Rehabilitation services

4. Family physician services

3. Diagnostic services

5. General medical services

1. Family physician services

Please consider the following:

The following questions are optional to answer, but your opinion will assist us.



Community Medical Manpower Questionnaire (Con't.) (4)

10. Public Health services and welfare services often provide assistance to the physician in the case of a patient - do you have suggestions for improvement? -----

11. Any other remarks -----

Date -----

Signed -----

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27 Aug 1944



APPENDIX VI.

SURVEY OF GENERAL PRACTICE IN CANADA

TENTATIVE TABLE OF CONTENTS

Preface

INTRODUCTION

i. Origin and purpose of the Survey of General Practice

ii. Methods and personnel

THE GENERAL PRACTITIONER

iii. The general practitioner's background

iv. The general practitioner's education

v. The general practitioner's career; vicissitudes of planning and practice

vi. Practice arrangements; within the office

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viii. Practice arrangements; time

ix. The general practitioner and the hospital

x. The general practitioner and the medical profession

xi. The general practitioner and the pharmaceutical industry

xii. The general practitioner and the community

xiii. Financial aspects of the general practitioner's career

xiv. The general practitioner as a person

THE WORK OF THE GENERAL PRACTITIONER

xv. The content of the general practitioner's work

xvi. The quality of general practice: method of practice

xvii. The quality of general practice: observations

xviii. Factors related to the quality of practice

SURVEY OF GENERAL PRACTICE IN CANADA

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- iv. The general practitioner's education
- v. The general practitioner's career; vicissitudes of planning and practice
- vi. Practice arrangements; within the office
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- ix. The general practitioner and the hospital
- x. The general practitioner and the medical profession
- xi. The general practitioner and the pharmaceutical industry
- xii. The general practitioner and the community
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- xxii. Some problems of general medical practice
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- xxiv. Responsibility in medicine
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APPENDIX VII

COMMUNITY QUESTIONNAIRE
PREPARED BY SPECIAL RESEARCH COMMITTEE
MEDICAL SOCIETY OF NOVA SCOTIA
AUGUST, 1961

PART I: GENERAL.

a. Name Sex: M. F .. Year of Birth: ... Marital Status: S. M. W. S, D...

b. Address County:

c. Length of time at this address If less than 2 years, previous address:

d. Education:

e. If unmarried: Are you living at home?

f. If living at home, position in family; father mother ... other

g. Number in family: 1st children and dependants:

Children

Dependents

Name	Age	Sex	Name	Age	Sex
...

[illegible]

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[The page contains several vertical columns of small dots or marks.]

.....

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[illegible]

.....



COMMUNITY QUESTIONNAIRE (Cont'd.) (2)

PART II: MEDICAL CARE.

- a. Do you have a family physician? ... If so, are you satisfied with (a) the services rendered?
(b) the relationship with the doctor?
- b. When did you or a member of your family last have services from your physician?
- c. Do you have regular medical check-ups? ... How Often? When was the last?
- d. Do the members of your family have regular medical check-ups? How often?
- e. If the answer to the above is no, why not?
- f. Have you and your family been inoculated for: No. of members inoculated: List names not inoculated:
- | | |
|-------------------------------|-------|
| Diphtheria..... | |
| Whooping cough..... | |
| Tetanus | |
| Polio | |
| Vaccinated for: Smallpox..... | |
| Tested for: T. B..... | |
- g. Does anyone in the family at home suffer from a chronic illness or disability? (Give member(s) and illness/disability):
.....
- h. Has anyone in your family suffered a serious illness or accident in the last 2 years?
(fill in form for each illness or accident)
- i. Name & Age Nature of illness or accident:
- j. How much time was lost from work, etc. due to this?
- k. Services received and expenses incurred:

(a) Medical:

House calls (number)
Official calls (number)
Out-patient clinic visits (number)
Specialist consultation services
Total expense of above

(a) Medical:

Official cards (number)
Home cards (number)

h. Services received and expenses incurred:

i. Has anyone in your family suffered a serious illness or accident in the last 5 years?

(List in form for each illness or accident)

j. If the answer to the above is no, why not?

k. Do the members of your family have regular medical check-ups? How often?

l. Do you have regular medical check-ups? How often? When was the last?

m. Do you have a family physician? ... If so, are you satisfied with (a) the services rendered? ...
(b) the relationship with the doctor?



COMMUNITY QUESTIONNAIRE (Cont'd.) (3)

- (b) Drugs: Number of prescriptions.....
Expense
- (c) Hospital Services: Length of stay.....
Expense
- (d) Operations: Number and type
Expense
- (e) Travelling expenses: Mode
(if applicable) Expense
- (f) Others (home nursing, convalescent, rehabilitation, etc.)
1. Was difficulty encountered in obtaining any of the above (k) State which and reason
-
- m. Were you unable to obtain any of above (k) State which and reason (not available, expense, etc.)
-
- N. What were the family medical expenses (for doctors only) for the last 12 months?
- o. Were you able to meet the above expenses?
- p. Were specialist services required by the family?..... If yes, were you able to obtain such services in your community?
- q. Was the patient covered by any form of health/sickness/hospital insurance?
- If so, what plan? (particulars of plan)
-
- What proportion of what expenses did it meet?

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1. If so, what plan? (particulars of plan)

2. Were specialist services required by the family? If yes, were you able to obtain such services in your

3. Were you able to meet the above expenses?

4. What were the family medical expenses (for doctors only) for the last 12 months?

5. Were you unable to obtain any of above (x) State which and reason (not available, expense, etc.)

(1) Others (home nursing)

(2) (if applicable)
travelling expenses:

(3) Operations:

Expense
Mode

Number and type

Expense



COMMUNITY QUESTIONNAIRE (Cont'd.) (4)

Are you still covered by it?..... Have you obtained any additional coverage?.....

Give particulars

r. If not covered at the time of the above illness/disability are you now covered by some insurance plan?.....

Give particulars.....

If not, why?.....

Do you wish to pay for your doctor's services (a) personally to him.....

(b) through a prepaid medical services insurance plan.....

(c) through a tax supported government plan.....

Reasons for choice.....

t. Are you able to get the dental services needed?..... If not, why?.....

(1) Do you feel you are receiving adequate health services?.....

(2) What medical/dental services do you feel you and your family need but are presently lacking?.....

.....

(3) What improvements would you wish made?.....

.....

Interviewer's remarks and comments:

(2) What improvements would you wish made?

(3) What medical/dental services do you feel you and your family need but are presently lacking?

(1) Do you feel you are receiving adequate health services?

If you are to get the dental services needed?

Reasons for choice

(a) through a tax supported Government plan

Do you wish to pay for your doctor's services (a) personally to him

If not, why?

If not covered at the time of the above illness/disease, are you now covered by some insurance plan?

Are you still covered by it? Have you obtained any additional coverage?

Continued on next page



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PART III: ECONOMIC BACKGROUND - OPTIONAL.

- a. Are you gainfully employed?..... Check for: Temporarily unemployed..... Work part time
- b. Are others in the family gainfully employed?..... Temporarily unemployed Work part time
- c. Are any of the family presently in school, college, etc.? Particulars
- d. Are there other sources of income for the family (pensions, allowances, etc.)? List:
.....
.....
.....
- e. Check family income bracket: \$1,600 and over ... \$5,000 and over ...
\$2,000 and over ... \$7,500 and over ...
\$3,000 and over ... \$10,000 and over ...
\$4,000 and over ... \$20,000 and over ...
- f. Dwelling: Condition..... No. of rooms No. of occupants
- g. No. of other occupants in dwelling who are not members of the family (boarders, servants, other families, etc.)
.....
- h. Do you own your own home? Mortgaged Rented Other?
- i. Appliances : (check off list below and give number if there are more than one)
Vacuum cleaner
Washing machine
Dryer
Dishwasher
Sewing machine
Television.....
Radio
Record player
Others
.....
- j. Refrigeration: Mechanical Ice Root cellar or equivalent If none of these, describe means used:
.....
- k. Heating: Furnace Stove Space Heater Fireplace
- l. Drinking water: Water under pressure Water chlorinated

Refrigeration: Mechanical Ice Hot cellar or equivalent If none of these, describe means used:

Washing machine

Radio

Finances: (check all that apply and give number if there are more than one)

Do you own your own home? Mortgaged Rented Other?

Dwelling: Condition No. of rooms No. of occupants

\$3,000 and over ...

\$10,000 and over ...

Check family income bracket: \$1,000 and over ... \$2,000 and over ...

Are there other sources of income for the family (pensions, allowances, etc.)? List:

Are any of the family presently in school, college, etc.? Particulars

Are you personally employed? Check for: temporarily unemployed Work part time

Form III: BRO-1110 (Rev. 1-1-41)



COMMUNITY QUESTIONNAIRE (Cont'd.) (6)

- Source: Well Spring River Lake City or town system Other
- m. Milk: Pasteurized Unpasteurized Powdered Other
- n. Sanitary facilities: Flush toilet Chemical toilet Outdoor privy Bathtub or shower
- Washbasin Kitchen sink
- o. Do you have a telephone?
- p. Do you have a car(s)? Other transport (specify)
- Remarks or comments of interviewer on Part III:

Remarks or comments of interviewer on Part III:

b. Do you have a car(s)? Other transport (specify)

c. Do you have a telephone?

.....

.....

.....

Source: Well Spring River Lake City or town system Other

APPENDIX VIII

MARITIME MEDICAL CARE INCORPORATED

Realizing the need for a type of medical care program which would provide the residents of Nova Scotia with a high standard of medical care at reasonable cost, the medical profession of the Province created Maritime Medical Care Incorporated. The corporation was set up by a special Act of the Legislature of the Province on April 29th, 1948.

The affairs of the Corporation are conducted by a Board of Directors consisting of seventeen members; twelve of the members are medical practitioners elected from the Branch Societies in Nova Scotia and five are non-medical members chosen from the public at large. Together, they represent those "providing" the services and those "receiving" the services offered by the Plan.

Non-profit by design, the Corporation's objective is, by means of voluntary enrolment of persons in its own coverage area, to provide a comprehensive program of medical care in which the benefits to the patient are on a "paid in full" basis at general practitioner level.

With the rapid growth of medical specialization and the many advances in medical therapy and techniques since the Corporation was first formed, Maritime Medical Care Incorporated has expanded the original field of benefits to include many services provided by specialists.

During the Plan's growth in size and in scope of benefits the subscriber premiums have been kept to a minimum consistent with the benefit level being offered to the public. This fact is borne out by the following

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table which indicates the percentage of each premium dollar returned to the member in the form of medical benefits:

% of Subscription Income Paid for Benefits

1956 - 92.15 1959 - 86.39

1957 - 93.77 1960 - 88.31

1958 - 87.75

The growth of the Plan since its inception is a clear indication of the public and professional acceptance to this method of providing for the Province's medical care needs. By the end of June 1961 enrolment totalled over 140,000 persons, making Maritime Medical Care the largest single underwriter of prepaid medical care insurance in the Province of Nova Scotia. In addition to the 140,000 persons enrolled as participants in Maritime Medical Care 665 medical practitioners in the Province of Nova Scotia have signed participating physician agreements with the Corporation. By signing a Participating Physician Agreement* the doctor agrees to render services to members of Maritime Medical Care and submit his accounts for such services directly to the Plan.

The success of the Plan can be attributed in part to the following features:

(1) The subscriber is free to obtain medical care for himself and his dependents from a doctor of his own choosing.

(2) The subscriber is free to choose the level of benefits he feels are needed for himself and his family.

(3) The subscriber is assured of a maximum

*Agreement appended.

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*Agreement appended.



1 return for each premium dollar spent due to the non-
2 profit principle under which the Plan operates.

3 (4) The doctor is free to decide the type of
4 care best suited for the patient.

5 (5) The doctor is free to negotiate (through
6 the Medical Society of Nova Scotia) the basis of
7 remuneration for his services.

8 The Plan has not interfered with the doctor-
9 patient relationship, but has fostered the provision of
10 a high quality of medical care to the subscribers. The
11 subscriber, by payment of a reasonable monthly premium
12 is free to call the doctor of his choice whenever he
13 feels the need for medical attention for himself or his
14 dependents, knowing full well that he will receive all
15 the necessary doctor services without fear of financial
16 embarrassment. The doctor, on the other hand, feels free
17 to render all necessary medical care to his patient.

18 As the Corporation grows and gains experience in
19 its particular field of operations, new refinements are
20 made to the existing program, which benefit the public
21 and the medical profession alike. The most popular
22 program presently offered by Maritime Medical Care is its
23 Group Comprehensive Plan* which presently covers
24 approximately 130,000 persons. This program provides a
25 member and his dependents with protection including home
26 and office calls, consultations, surgery, maternity,
27 diagnostic and some preventive medical services. The
28 cost of his program to a family of three or more is \$9.00
29 per month. Under this program many employers pay all or a
30 portion of the premium on behalf of their employees,
* Contracts Appended.

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Maritime Medical Care Plan

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member and his dependents with protection including home

and office visits, hospitalization, surgery, ambulance

diagnostic and some preventive medical services. The

cost of his program to a family of three or more is \$2.00

per month. Under this program many employers pay all or a

portion of the premium on behalf of their employees.

* Contracts Attached.



1 with the result that the direct cost to the subscriber
2 is less than indicated.

3 The Corporation also offers a Health Security
4 Plan * which was designed for those persons who, although
5 prepared to assume the risk for the cost of their own
6 routine home and office care, desire protection against
7 the cost of major medical and/or surgical procedures and
8 prolonged hospital stay. The Health Security Plan
9 therefore provides coverage for all doctors' services
10 required by the subscriber while confined to the hospital.
11 The family rate for this coverage is \$3.60 per month.

12 Both the Comprehensive Plan and the Health
13 Security Plan are offered on a group basis to employers
14 with as few as five employees. Both programs provide
15 coverage for chronic or pre-existing conditions, and both
16 programs are available to persons regardless of age.
17 When a group member retires he can continue with the
18 same level of benefits he enjoyed as a member of the
19 group if he so chooses. Because all residents of Nova
20 Scotia are not eligible for membership in one of
21 Maritime Medical Care's groups, the Corporation has
22 designed special programs for non-group members.

23 The Individual Contract Plan * is available to
24 all persons under sixty years of age who are not eligible
25 for group membership. This Plan offers benefits comparable
26 to those available to group members enrolled in our
27 comprehensive program, including home and office calls.

28 Under an Individual Contract type of Plan, the underwriter
29 *Contracts appended.
30



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Under an Individual Contract type of Plan, the underwriter



1 must protect his membership against those persons who may
2 wish to join to meet a temporary emergency and then
3 cancel their coverage once the needed benefit has been
4 obtained, leaving the remaining members of the plan to
5 absorb the loss. As a result, the Individual Plan does
6 not cover the applicant for treatment of conditions
7 existing at the date of application.

8 For many years the doctor-sponsored plans have
9 been concerned over the lack of programs for the aged,
10 with the result that in October 1960 Maritime Medical Care
11 became the first doctor-sponsored plan in Canada to offer
12 a special contract for such persons.

13 The Seniors' Health Plan** is available to the
14 senior citizens of the Atlantic area who are sixty years
15 of age or over and their dependents. The Plan provides
16 complete medical care while the subscriber is in hospital,
17 and also covers the doctor's services for surgical and
18 certain other emergency care in the patient's home or
19 Doctor's office. This Plan includes treatment of chronic
20 or pre-existing conditions and the waiting periods for
21 certain surgical benefits have been reduced to a minimum.
22 The response of the public to this new program, which
23 recently completed its first year in operation, clearly
24 indicates to the Corporation that the Seniors' Health
25 Plan is meeting a definite need in the Atlantic area. At
26 the present time over 9,000 persons are enrolled in this
27 new program. As further experience is gained it is the
28 hope of the Corporation and its sponsors that the range
29 of benefits may be broadened to include additional home
30 and office care and a further reduction in the maximum
** Contracts appended.



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1 waiting periods of six months for surgery.

2 With the introduction of the Seniors' Health Plan,
3 Maritime Medical Care Incorporated became the first Plan
4 in the Atlantic area and one of the few in Canada who
5 offered a sufficient variety of medical care programs so
6 as to enable all residents in their coverage area to
7 obtain medical care insurance, should they wish to do so.

8 Premiums have, over the years, been kept at a
9 minimum level consistent with the range and volume of
10 benefits received by the subscriber, with a view to
11 keeping the cost of the program at a level that enables
12 the average wage earner to belong to the particular plan
13 of his own choosing.

14 Regardless of premium levels, however, there are
15 always those members of the community who wither cannot,
16 or will not, participate in a program such as that offered
17 by Maritime Medical Care. In a free society there will
18 always be a number of individuals who do not support the
19 insurance principle for the provision of their medical
20 care requirements and are prepared to provide for their
21 own medical needs without assistance. The plan, being a
22 supporter of a voluntary system of medical care insurance,
23 respects the feelings of this group.

24 Maritime Medical Care Incorporated is concerned
25 about those members of the community who cannot afford to
26 belong to a voluntary prepayment plan because of their
27 inability to pay the necessary premium, no matter what
28 that premium might be. The Government of the Province
29 of Nova Scotia and the Medical Society of Nova Scotia
30 have also been concerned over this group. As a necessary

waiting periods of six months for surgery.

With the introduction of the Seniors' Health Plan Maritime Medical Care Incorporated became the first Plan in the Atlantic area and one of the few in Canada who offered a sufficient variety of medical care programs so as to enable all residents in their coverage area to obtain medical care insurance, should they wish to do so. Premiums have, over the years, been kept at a minimum level consistent with the range and volume of benefits received by the subscriber, with a view to keeping the cost of the program at a level that enables the average wage earner to belong to the particular plan of his own choosing.

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1 step in the solution to this problem, an agreement was
2 reached in 1950 between the Department of Public Health
3 and Welfare of this Province, (now the Department of
4 Public Welfare), and the Medical Society of Nova Scotia,
5 for the provision of medical care to certain recipients
6 of welfare assistance. (Appendix IX). Under this program
7 the level of benefits, the amount of reimbursement to
8 physicians and a premium for each recipient was agreed
9 upon between the Department and the Medical Society,
10 with Maritime Medical Care providing its experienced
11 personnel and administrative facilities for the handling
12 of this program. At the present time approximately ten
13 thousand persons receive benefits through Maritime
14 Medical Care Incorporated under this program. It is the
15 hope of the Corporation and the Medical Society of Nova
16 Scotia that, in time, other segments of the population
17 who are unable to meet the cost of health care will be
18 included in this or similar programs. The amount of
19 government participation in the payment of premiums
20 could vary with the financial level of each group
21 concerned. As an example, Old Age Pensioners benefited
22 in the original plan until the Federal Government took
23 over full payment of these pensions.

24 Looking to the future, Maritime Medical Care
25 Incorporated is presently studying additional benefits
26 which may be offered to supplement its basic programs
27 for physicians' services. This supplementary program,
28 when developed, will provide the subscribers with coverage
29 for many of the services ordered by the attending
30 physician during the patient's course of treatment.



step in the solution to this problem, an agreement was reached in 1955 between the Department of Public Health and Welfare and the Department of Health Services, and the Hospital Industry in 1956, for the provision of medical care to certain residents of certain institutions. (Exhibit 11) Under this program the level of benefits, the amount of reimbursement to hospitals and a number of other matters are agreed upon between the Department and the Hospital Industry. With certain special provisions for certain institutions and certain types of services, the program is administered by the Hospital Industry. It is estimated that approximately 100,000 persons receive benefits through Maritime Medical Care Incorporated under this program. It is the hope of the Corporation and the Medical Society of Nova Scotia that, in time, other segments of the population who are unable to meet the cost of health care will be included in this or similar programs. The amount of government participation in the payment of premiums could vary with the financial level of each group. It is estimated that the Maritime Medical Care Corporation, in the original plan until the Federal Government took over full payment of these pensions. Incorporated is presently studying additional benefits and the effect on the program. The supplementary program, when developed, will provide the subscribers with coverage for many of the services ordered by the attending physician during the patient's course of treatment.

1 Included in the benefits would be the cost of drugs,
2 special appliances, physiotherapy, nursing care and other
3 para-medical services. During the years the Plan has been
4 in operation every effort has been made and will continue
5 to be made, to keep its program abreast of modern medical
6 advances.

7 The Corporation's method of operation lends
8 itself well to providing a variety of programs, whether
9 they be completely financed by the individual participants,
10 partly financed by the individual with government
11 assistance or completely financed by the government, in
12 the case of those unable to meet a portion of the costs
13 of their own health care requirements.

14 Since the Plan was first introduced to the people
15 of Nova Scotia in 1949, it has been responsible for the
16 creation and development of a program of health care
17 which enables both patient and doctor to work together
18 on a basis acceptable to both parties, with minimum loss
19 of any of the normal relationships that exist between
20 them.
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Included in the benefits would be the cost of drugs, special appliances, physiotherapy, nursing care and other para-medical services. During the years the Plan has been in operation every effort has been made and will continue to be made, to keep its program abreast of modern medical advances.

The Corporation's method of operation lends

itself well to providing a variety of programs, whether they be completely financed by the individual participants partly financed by the individual with government assistance or completely financed by the government, in the case of those unable to meet a portion of the costs of their own health care requirements.

Since the Plan was first introduced to the people

of Nova Scotia in 1949, it has been responsible for the creation and development of a program of health care which enables both patient and doctor to work together on a basis acceptable to both parties, with minimum loss of any of the normal relationships that exist between



A P P E N D I X V I I I - A

MARITIME MEDICAL CARE INCORPORATED

1. Participating Physician Agreement
2. Subscribers' Contracts.
 - Medical, Surgical and Obstetrical
 (Comprehensive) Plan
 - Individual Plan
 - Health Security Plan
 - Seniors' Health Plan



1944-1945

ANNUAL REPORT OF THE SECRETARY

Particulars of the Secretary's Report

Subscribers, Congress.

- Medical, Surgical and Obstetrical
(continued) (1944)

- Continued from

Health, 1944, 1945

- Seniors, Health Plan

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APPENDIX IX

PERTINENT EXCERPTS FROM AGREEMENT BETWEEN THE
DEPARTMENT OF PUBLIC WELFARE AND THE MEDICAL SOCIETY
OF NOVA SCOTIA (MAY 1960).

"For the purpose of this Agreement:

1. (a) "receptient" means:

- (i) a person to whom or on whose behalf assistance is paid pursuant to the Blind Persons Act;
- (ii) a child on whose behalf assistance is paid pursuant to sub-section (a) of Section 7 of the Social Assistance Act;
- (iii) the mother or father of a child on whose behalf assistance is being paid pursuant to sub-section (a) of Section 7 of the Social Assistance Act;
- (iv) a child in the care and custody of a person to whom assistance is being paid pursuant to sub-section (b) of Section 7 of the Social Assistance Act.

(b) "Medical Services" includes:

- (i) medical services and attention in the residence of a recipient;
- (ii) medical advice and attention in the office of a member of the Society;
- (iii) Medical advice and attention in hospital for a maximum stay of twelve days;
- (iv) tonsillectomies when performed by a qualified practitioner;
- (v) obstetrical care, including prenatal and postnatal care;
- (vi) refractions for children up to fifteen years;
- (vii) surgery in the case of minor accidents;
- (viii) surgery in hospital for a maximum stay of twelve days;
- (ix) fractures that may be treated at

APPENDIX IX

PERTINENT EXCERPTS FROM AGREEMENT BETWEEN THE
GOVERNMENT OF CANADA AND THE PROVINCE OF NOVA SCOTIA
(MAY 1960).

"For the purpose of this Agreement:

"recipient" means: (a) 1.

(i) a person to whom or on whose behalf assistance is paid pursuant to the Blind Persons Act;

(ii) a child on whose behalf assistance is paid pursuant to sub-section (a) of Section 7 of the Social Assistance Act;

(iii) the mother or father of a child on whose behalf assistance is being paid pursuant to sub-section (a) of Section 7 of the Social Assistance Act;

(iv) a child in the care and custody of a person to whom assistance is being paid pursuant to sub-section (b) of Section 7 of the Social Assistance Act.

"Medical Services" includes:

(i) medical services and attention in the residence of a recipient;

(ii) medical advice and attention in the office of a member of the Society;

(iii) Medical advice and attention in hospital for a maximum stay of twelve days;

(iv) tonilllectomies when performed by a qualified practitioner;

(v) obstetrical care, including prenatal and postnatal care;

(vi) refractions for children up to

(vii) surgery in the case of minor

(viii) surgery in hospital for a maximum stay of twelve days;

(ix) fractures that may be treated at



1 home or in hospital;
2 but do not include:

3 (i) surgery except as indicated in
4 (iv), (v) and (vii) and (viii)
5 above;

6 (ii) medical aids, appliances or
7 supplies".

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home or in hospital;
but do not include:

(1) surgery except as indicated in
(iv), (v) and (viii)
above;

(ii) medical aids, appliances or
"supplies".

APPENDIX X

PARA-MEDICAL PERSONNEL

1. Registered Nurses
2. Certified Nursing Assistants
3. Orderlies
4. Dietitians
5. Medical Social Workers
6. Medical Record Librarians
7. Psychologists
8. Physiotherapists
9. Occupational Therapists
10. Speech Therapists
11. Medical Photographers
12. Cardiological Technicians
13. Technical Personnel for the Operation and
Assistance of Heart Pumps
14. Brace and Appliance Maker
15. Vocational Counsellors
16. Electrocardiograph Technicians
17. Electroencephalograph Technicians
18. X-Ray Technicians
19. Laboratory Technicians
20. Radiation Therapy Technicians
21. Pharmacists



APPENDIX A

LAND-RELATED OCCUPATIONS

1. Land Surveyors
2. Geologists
3. Orderlies
4. Dietitians
5. Medical Social Workers
6. Medical Record Librarians
7. Radiologists
8. Radiographers
9. Hospital Tourists
10. Speech Therapists
11. Medical Photographers
12. Hospital Administrators
13. Technical Personnel for the Operation and Assistance of Heart Pumps
14. Brace and Appliance Maker
15. Vocational Counselors
16. Electrocardiograph Technicians
17. Electroencephalograph Technicians
18. X-Ray Technicians
19. Laboratory Technicians
20. Radiology Technicians
21. Radiologists



APPENDIX IX

HOSPITALS WITH NURSING SCHOOLS

Halifax Infirmary
Victoria General Hospital
Grace Maternity Hospital
Children's Hospital
(all in Halifax)
Payzant Memorial - Windsor
Yarmouth Hospital - Yarmouth
Nova Scotia Hospital -
Dartmouth
Aberdeen Hospital - New
Glasgow
St. Martha's - Antigonish
City of Sydney - Sydney
St. Rita's - Sydney
Glace Bay General - Glace Bay
St. Joseph's - Glace Bay
St. Elizabeth's - North Sydney

HOSPITALS WITH NURSING
ASSISTANT SCHOOLS

Halifax Infirmary -
Halifax
Camp Hill Hospital -
Halifax
Nova Scotia Hospital -
Dartmouth
St. Martha's -
Antigonish
N. S. Sanatorium -
Kentville

UNIVERSITIES WITH
NURSING DEGREES

Dalhousie - Halifax
(School of Nursing)
Mount St. Vincent College
Rockingham
(5 year course)
St. Francis Xavier -
Antigonish
(no one has attended
in recent years)

T.B. Affiliated Schools

W. S. Sanatorium - Kentville
Point Edward Hospital - Sydney

APPENDIX III

HOSPITALS WITH NURSING COURSES

Halifax Infirmary -
Halifax
Camp Hill Hospital -
Halifax
Nova Scotia Hospital -
Dartmouth
St. Martha's -
Halifax
N. S. Sanatorium -
Kentville

UNIVERSITIES WITH NURSING COURSES

Bathurst - Halifax
(School of Nursing)
Dalhousie University -
Halifax
(5 year course)
St. Joseph's -
Halifax
(no one has attended
in recent years)

HOSPITALS WITH NURSING COURSES

Halifax Infirmary -
Halifax
Victoria General Hospital
Grace Maternity Hospital
Children's Hospital
(all in Halifax)
Payzant Memorial - Windsor
Yarmouth Hospital - Yarmouth
Nova Scotia Hospital -
Dartmouth
Aberdeen Hospital - New
Glasgow
City of Sydney - Sydney
St. Rita's - Sydney
Gloucester Bay General - Gloucester Bay
St. Joseph's - Gloucester Bay
St. Elizabeth's - North Sydney

W. S. SANATORIUM - KENTVILLE

Point Edward Hospital - Sydney



APPENDIX XII

NOVA SCOTIA

FEDERAL HEALTH GRANT PROJECTS

1961-62

Courtesy of the Department of Public Health

GRANT
NUMBERS

I. PROFESSIONAL TRAINING GRANT (OUTRIGHT)

602-2-14	Post-Graduate Training in Public Health Nursing
602-2-16	Post-graduate Training of Nurses
602-2-30	Post-Graduate Training of Medical Health Officers
602-2-31	Training Physio and Occupational Therapists
602-2-32	Training Hospital Administrators
602-2-37	Short Courses in Professional Training
602-2-39	Training in Pathology
602-2-40	Training Medical Records Librarians
602-2-44	Training in X-ray Technology - Therapy
602-2-45	Training Social Workers
602-2-46	Training Hospital Dietitians
602-2-47	Training Hospital Pharmacists
602-2-48	Training in Speech Pathology and Audiology

II. MENTAL HEALTH GRANT (OUTRIGHT)

602-5-1	Sydney Mental Health Clinic
602-5-2	Assistance to Mental Health Divisions
602-5-8	Training of Graduate Physicians in Psychiatry
602-5-9	Maritime School of Social Work
602-5-17	Post-Graduate Training in Clinical Psychology at Dalhousie University
602-5-26	Training in Psychiatry

NOVA SCOTIA

1961-62

Courtesy of the Department of Public Health

I. PROFESSIONAL TRAINING GRANT (OUTRIGHT)

GRANT

Post-Graduate Training in Public Health

Post-graduate Training of Nurses

Post-Graduate Training of Medical Health
Officers

Training Physio and Occupational Therapists

Training Hospital Administrators

Short Courses in Professional Training

Training in Pathology

Training in X-ray Technology - Therapy

Training Social Workers

Training Hospital Pharmacists

Training in Speech Pathology and Audiology

II. GRANT IN AID

Sydney Mental Health Clinic

Assistance to Mental Health Divisions

Training of Graduate Physicians in Psychiatry

Maritime School of Social Work

Post-Graduate Training in Clinical Psychology
at Dalhousie University

Training in Psychiatry



II. MENTAL HEALTH GRANT (OUTRIGHT) Continued

- 602-5-28 Training in Psychiatric Social Workers
- 602-5-33 Training Teachers in Mental Health for
Schools
- 602-5-38 Assistance to Nova Scotia Hospital
- 602-5-40 Training Psychologists
- 602-5-43 Halifax Mental Health Clinic for Children
- 602-5-44 Short Courses in Mental Health
- 602-5-46 Fundy Mental Health Clinic
- 602-5-49 Western Mental Health Clinic
- 602-5-52 Psychosomatic Factors in the Prediction and
Control of Complications in Pregnancy
- 602-5-53 Relationship of Amino Acids and Protein
Metabolism to Mental Retardation and/or
Convulsions in Infants and Children
- 602-5-54 Cabeguid Mental Health Service
- 602-5-55 Yarmouth Mental Health Clinic
- 602-5-56 Eastern Counties Mental Health Clinic

III. TUBERCULOSIS CONTROL GRANT (OUTRIGHT)

- 602-6-31 Tuberculosis Control Program
- 602-6-10 Streptomycin, para-amino salicylic acid,
isoniazid
- 602-6-12 Assistance to Point Edward Hospital
- 602-6-13 Assistance to Nova Scotia Sanatorium
- 602-6-18 Rehabilitation - Nova Scotia Sanatorium
- 602-6-19 Rehabilitation - Point Edward Hospital
- 602-6-34 Division of Laboratories - Public Health
- 602-6-36 Tuberculin Heaf Test Surveys

IV. PUBLIC HEALTH RESEARCH GRANT
(Competition at Federal Level)

- 602-7-23 The effectiveness of Antimicrobial Therapy
in Tuberculin Converters in Common School
Children and B.C.G. Vaccination of High
School Students in Reducing T.B. Morbidity
(Clinical) in the Adolescent and Young Adult

602-5-26	Training in Psychiatric Social Workers	2
602-5-33	Training Teachers in Mental Health for Schools	3
602-5-38	Assistance to Nova Scotia Hospital	4
602-5-40	Training Psychologists	5
602-5-44	Short Courses in Mental Health	6
602-5-49	Western Mental Health Clinic	9
602-5-52	Psychosomatic Factors in the Prediction and Control of Complications in Pregnancy	10
602-5-53	Relationship of Amino Acids and Protein Metabolism to Mental Retardation and Convulsions in Infants and Children	11
602-5-56	Eastern Counties Mental Health Clinic	12
602-5-56	<u>TUBERCULOSIS CONTROL GRANT (OVERTIGHT)</u>	13
602-6-10	Streptomycin, para-amino salicylic acid, Isoniazid	14
602-6-12	Assistance to Point Edward Hospital	15
602-6-15	Assistance to Nova Scotia Sanatorium	16
602-6-18	Rehabilitation - Nova Scotia Sanatorium	17
602-6-19	Rehabilitation - Point Edward Hospital	18
602-6-34	Division of Laboratories - Public Health	19
602-6-36	Tuberculin Heat Test Surveys	20
602-7-23	<u>PUBLIC HEALTH RESEARCH GRANT</u> (Competition at Federal level)	21
602-7-23	The effectiveness of Antimicrobial Therapy in the Adolescent and Young Adult (Clinical)	22
602-7-23	Children and B.C.G. Vaccination of High School Students in Reducing T.B. Morbidity	23



IV. PUBLIC HEALTH RESEARCH GRANT Continued

- 602-7-24 Laboratory Diagnostic Study of Neurotropic Viruses in the Four Maritime Provinces.
- 602-7-34 A Search for Viral Infection of the Foetal Membranes as a Factor in Foetal Loss
- 602-7-37 Field Trials of Monovalent and Biovalent Live Poliovirus Vaccine
- 602-7-39 The Effect of Leucine Administration to Juvenile Diabetes Mellatus Patients

V. GENERAL PUBLIC HEALTH GRANT (OUTRIGHT)

- 602-9-2 Industrial Hygiene
- 602-9-4 Public Health Nursing Education Course
- 602-9-27 Division of Dental Hygiene
- 602-9-29 Assistance to Public Health Field Services
- 602-9-32 Nutrition Division
- 602-9-42 Training Public Health Nurses and Nutritionists
- 602-9-52 Mobile Arthritis Unit
- 602-9-55 Course in Hospital Organization and Management
- 602-9-60 Training Dental Hygienists
- 602-9-62 Central Office
- 602-9-64 Purchase of Health Education Equipment and Material
- 602-9-66 Laboratory - General Public Health - Equipment and Services
- 602-9-72 V. D. Control Program
- 602-9-73 Training of X-Ray Technicians
- 602-9-74 Extension of Services - Laboratory and Radiological Services.
- 602-9-75 Training of Laboratory Technicians
- 602-9-76 Short Courses for Training Laboratory and Radiological Personnel
- 602-9-77 Public Health Technical Advisory Service
- 602-9-71 Glaucoma Clinics



GRANT Continued

Laboratory Diagnostic Study of Neurotropic
Viruses in the Four Maritime Provinces.

A Search for Viral Infection of the Foetal
Membranes as a Factor in Foetal Loss

Field Trials of Monovalent and Bivalent
Live Poliovirus Vaccines

The Effect of Insulin Administration to
Juvenile Diabetes Mellitus Patients

V.

Laboratory Studies

Field Studies

Division of Dental Hygiene

Assistance to Public Health Field Services

Nutrition Division

Training Public Health Nurses and
Midwives

Mobile Antibiotic Unit

Course in Hospital Organization and Management

Public Health Statistics

Central Office

Purchase of Health Education Equipment and
Materials

Laboratory - General Public Health -
Equipment and Services

V. D. Control Program

Training of X-Ray Technicians

Expansion of Services - Laboratory and
Diagnostic Services

Training of Laboratory Technicians

Short Courses for Training Laboratory and
Radiological Personnel

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VI. CANCER CONTROL GRANT (MATCHING)

602-10-2 Cancer Control Program

VII. MEDICAL REHABILITATION AND CRIPPLED CHILDREN GRANT (MATCHING)

602-12-1 Medical Rehabilitation Services

602-12-3 Training Medical Rehabilitation Personnel

602-12-4 Brace Maker's Shop

602-12-6 Rehabilitation of Crippled and Handicapped Childred

602-12-7 Field Worker - N. S. Society for Care of Crippled Children

602-12-5 Training Physiotherapists (Not yet app.)

VIII. CHILD AND MATERNAL HEALTH GRANT (OUTRIGHT)

602-13-2 Training Nurses in Infant and Maternal Care

602-13-7 Division of Child and Maternal Health Services

602-13-8 Child Health Conferences and Pre-Natal Classes

602-13-10 Hearing Test Unit

602-13-13 Investigation of Maternal and Peri-Natal Mortality

602-13-14 Possible Connection Between Trichomonas Vaginalis in Mothers and Infection in the Newborn

IX. HOSPITAL CONSTRUCTION GRANT

Details on this grant do not permit of tabulation.



RESEARCH GRANTS - MEDICAL

Medical Research Services

Medical Research Services - Children

602-12-1	Medical Rehabilitation Services
602-12-3	Training Medical Rehabilitation Personnel
602-12-4	Brace Maker's Shop
602-12-6	Rehabilitation of Crippled and Handicapped Children
602-12-7	Field Worker - N. E. Society for Care of Crippled Children
602-12-5	Training Physiotherapists (Not yet app.)

VIII. Child Health and Maternal Care

602-13-2	Training Nurses in Infant and Maternal Care
602-13-7	Division of Child and Maternal Health
602-13-8	Child Health Conferences and Pre-Natal Classes
602-13-10	Investigation of Mortality
602-13-13	Investigation of Maternal and Peri-Natal Mortality
602-13-14	Possible Connection Between Trichomonas Vaginalis in Mothers and Infection in the

IX. HOSPITAL CONSTRUCTION GRANT

Details on this grant do not permit of tabulation.

APPENDIX XIII

Summary

PUBLIC HEALTH SERVICES

Provided by

Health Units

of

THE DEPARTMENT OF PUBLIC HEALTH - NOVA SCOTIA

1. SCHOOL HEALTH

Nursing Services

- (1) Act as consultant to the school teacher in school health problems.
- (2) Carry out the health inspection of school children as follows:
 - (a) Health inspection including vision and tuberculin testing on all children entering school for the first time.
 - (b) Examination of referrals from teacher.
 - (c) Re-inspection of children found to have health defects on previous examinations.
 - (d) Rapid inspections in special cases such as in the case of communicable disease or skin infestation.
 - (e) Vision testing in Grade VI.
 - (f) Assistance to local Medical Health Officers in respect to control of communicable diseases in the school.
 - (g) Assistance with Public Health teaching.

Audiomatic Testing Service is provided by three units being operated at the present time in the schools.

Nutrition Education Service

- (1) Provision of education materials.
- (2) Nutrition demonstrations; i.e., white rat experiments
- (3) Teaching assistance.



Summary

Health Unit

Health Unit

THE DEPARTMENT OF PUBLIC HEALTH - NOVA SCOTIA

Services

Nursing Services

- (1) Act as consultant to the school teacher in school health problems.
 - (2) Carry out the health inspection of school children as follows:
 - (a) Health inspection including vision and tuberculin testing on all children entering school for the first time.
 - (b) Examination of referrals from teacher.
 - (c) Re-inspection of children found to have health defects on previous examinations.
 - (d) Rapid inspections in special cases such as in the case of communicable disease or skin diseases.
 - (e) Vision testing in Grade VI.
 - (f) Assistance to local Medical Health Officers in respect to control of communicable diseases in the school.
 - (g) Assistance with Public Health teaching.
- Automatic Testing Service is provided by three units being operated at the present time in the schools.

Public Health Services

- (1) Provision of education materials.
- (2) Nutrition demonstrations; i.e., white rat experiments
- (3) Teaching assistance.

1 Nutrition Education Service-Continued

- 2 (4) Furtherance of the school lunch program and the
3 use of plain milk in the schools.
- 4 (5) Technical assistance in new school cafeteria
5 construction.
- 6 (6) Provision of special projects for teenagers or
7 special groups; i.e., lectures on food buying,
8 overweight projects, etc.
- 9 (7) Working and lecturing to: (1) Allied Youth Groups
10 (2) Normal School Pupils
11 (3) Dalhousie Summer
12 School Students
13 (4) Students at School for
14 Public Health
15 Nursing
16 (5) Students at Maritime
17 School of Social
18 Work

13 Dental Service

- 14 (1) Therapeutic: A complement of three mobile clinics
15 provide treatment services in rural
16 areas when staff is available.
- 17 (2) Preventive (a) Prophylaxis is provided by dentists
18 on the mobile clinics
19 (b) Prophylaxis is also provided for
20 by the Dental Hygienists. There
21 is an establishment for eight
22 hygienists. There are five on
23 staff at the moment.

20 Sanitation Services

- 21 (1) Approval of: (a) Sites for a new school construction.
22 (b) Plans for water supply
23 (c) Plans for sewage disposal
24 (d) Lighting
25 (e) Plumbing
- 26 (2) Approval of renovations with respect to above
- 27 (3) Maintenance of a Sanitary Inspection Service for
28 all schools.
- 29 (4) Bacteriological examination of water supplies
30 routinely.
- (5) Health education by lectures and films.

(4) Purchase of the school lunch program and the use of plain milk in the schools.

Technical assistance in new school cafeteria construction.

Provision of special projects for teenagers or special groups; i.e., lectures on food buying.

- (7) Working and lecturing to:
- (1) Allied Youth Groups
 - (2) Normal School Pupils
 - (3) Delinquent Summer School Students
 - (4) Students at School for the Deaf
 - (5) Students at Maritime School of Social Work

(11) Therapeutic: A complement of three mobile clinics provide treatment services in rural areas when staff is available.

(8) Preventive (a) Prophylaxis is provided by dentists on the mobile clinics

(b) Prophylaxis is also provided for by the Dental Hygienists. There is an establishment for eight Hygienists. There are five on staff at the moment.

(12) Approval of: (a) Sites for a new school construction

(b) Plans for water supply

(c) Plans for sewage disposal

(d) Lighting

(e) Plumbing

Approval of renovations with respect to above

(3) Maintenance of a Sanitary Inspection Service for all schools.

Bacteriological examination of water supplies routinely.

Sanitary inspection by dentists and Hygienists.

(6) Consultative service

II INFANT AND PRE SCHOOL HEALTH

Nursing Service

- (1) Home visiting
- (2) Child Health Conferences (about 50)
- (3) Child Health Clinics (2)
- (4) Attendance at Crippled Children's Clinics and provision of follow up after clinics.

Nutritionist Service

- (1) Attendance at Child Health Conferences
- (2) Consultative services on request

Dental Hygienist Service is extended to the pre school age group.

III MATERNAL HEALTH

Nursing Service

- (1) Prenatal home visiting.
- (2) Prenatal classes (9).
- (3) Prenatal guide is available to V.O.N. and city nurses, Doctors and hospitals.
- (4) Post natal visiting.

Nutritionist Service

Attendance at Prenatal classes.

IV COMMUNICABLE DISEASE CONTROL

- | | |
|---------------------------------|---------------------------------|
| (a) Tuberculosis Case findings: | (1) Tuberculin Surveys |
| | (2) X-Ray Clinics |
| | (3) X-Rays - local hospitals |
| | (4) Follow up of contacts |
| | (5) Rehabilitation of patients. |



II INFANT AND PRE SCHOOL HEALTH

Nursing Service

- (1) Home visiting
- (2) Child Health Conferences (about 50)
- (3) Child Health Clinics (2)
- (4) Attendance at Crippled Children's Clinics and provision of follow up after clinics.

Medical Service

- (1) Attendance at Child Health Conferences
- (2) Consultative services on request

Age Group

III MATERNAL HEALTH

Nursing Service

- (1) Prenatal home visiting.
- (2) Prenatal classes (9).
- (3) Prenatal guide is available to V.O.N. and city nurses, Doctors and hospitals.
- (4) Post natal visiting.

Nutritional Service

Attendance at Prenatal classes.

IV COMMUNICABLE DISEASE CONTROL

- (a) Tuberculosis Case (1) Tuberculin Surveys
- (3) X-Rays - local hospitals
- (4) Follow up of contacts
- (5) Rehabilitation of patients.



(6) Consultation

(7) Therapy

(b) Epidemiological studies when necessary; i.e., Typhoid

(c) Immunization - Emphasis is placed on early infant immunization for Diphtheria, Pertussis, Tetanus, Polio and Small-pox by (a) family physician and (b) community clinics.

Reinforcing immunization is available through the above channels.

(d) In venereal disease the Department pays fee for service to the attending physician in the treatment of venereal disease. Follow up of contacts is also provided.

PROVISION OF DRUGS

- (1) Gamma globulin
- (2) Diabetic drugs
- (3) Tuberculosis drugs
- (4) Antigens
- (5) Antitoxins (at cost price)

V PUBLIC HEALTH EDUCATION

Every phase of public health involves public or individual education. Mass media is used in special projects. All members of staff speak to community groups and agencies on request. Education material, special diet information and food budgeting service, are provided on request. Certain staff attend Folk Schools in a consultative capacity in co-operation with the Department of Adult Education.

VI ENVIRONMENTAL HEALTH

Milk

- (1) Administration of the Nova Scotia Milk Regulations in respect to pasteurized and raw milk.

(6) Consultation

(7) Therapy

(b) Epidemiological studies when necessary; i.e., Typhoid

(c) Immunization - Immunization is given to every infant, child, and adult for Diphtheria, Pertussis, Tetanus, Polio and Small-pox by (a) family physician and (b) health officer.

Reinforcing immunization is available through the health officer.

(d) In venereal disease the Department pays fee for service to the attending physician in the treatment of venereal disease. Follow up of contacts is also provided.

PHARMACEUTICALS

- (1) Gamma globulin
- (2) Diabetic drugs
- (3) Tuberculosis drugs
- (4) Antigens
- (5) Antitoxins (at cost prices)

V PUBLIC HEALTH EDUCATION

Every phase of public health involves public or individual education. Mass media is used in special projects. All members of staff speak to community groups and agencies on request. Education material, special diet information and food budgeting service, are provided on request. Certain staff attend Folk Schools in a consultative capacity in co-operation with the Department of Adult Education.

VI ENVIRONMENTAL HEALTH

- (1) Administration of the Nova Scotia Milk Regulations in respect to pasteurized and raw milk.



1 Milk - Continued

- 2 (2) Provision of inspection, sampling and
3 laboratory service for pasteurized and raw
4 milk processing
- 5 (3) Provision of consultative service and
6 quality control for milk processing plants;
7 i.e., temperature, resazurin, off-flavour,
8 etc.
- 9 (4) Recommendation for licensing of milk
10 producers.
- 11 (5) Regular inspection, consultation and
12 technical assistance to producers.

13 Water

- 14 (a) Public (1) Regular inspection, consultation,
15 technical assistance and
16 bacteriological examination.
- 17 (2) Approval of plans for new
18 installations and extensions.
- 19 (b) Private. As above on request.
- 20 (c) Surveys

21 Sewage Disposal

- 22 (a) Public
- 23 (1) Regular inspection,
24 consultation, technical
25 assistance and B.O.D.
26 estimations.
- 27 (2) Approval of plans for new
28 installations and extensions.
- 29 (b) Private. As above on request.
- 30 (c) Surveys.

31 Housing

32 Where regulations exist or when a request is
33 received, consultation and technical assistance is
34 provided in matters concerning water, sewage disposal,
35 etc.

36 Eating Establishments

37 An inspection service is provided where municipal-



(2) Provision of inspection, sampling and laboratory service for pasteurized and raw milk processing

Provision of inspection, sampling and laboratory service for milk processing plants; i.e., temperature, respiration, off-flavour, etc.

(4) Recommendation for licensing of milk producers.

(5) Regular inspection, consultation and assistance to producers.

(a) Public (1) Regular inspection, consultation and technical assistance and

(2) Approval of plans for new installations and extensions.

(b) Private. As above on request.

(c) Surveys

Sewage Disposal

(a) Public

(1) Regular inspection, consultation, technical assistance and

(2) Approval of plans for new installations and extensions.

(b) Private. As above on request.

Housing

Where regulations exist or when a request is

received, consultation and technical assistance is

provided in matters concerning water, sewage disposal,

Sanitary Establishments

An inspection service is provided where municipal-



ities have a restaurant by-law.

Tourist Accomodation

Co-operation with Department of Trade and Industry
in matters of sanitation in the above accommodation.

Miscellaneous services for:

Slaughter Houses	nuisances	rodent control
Fish Plants	food shops	insect control
Bake Shops	refuse disposal, etc.	

VII INSTITUTIONAL HEALTH

- (1) Tuberculin surveys for county homes and county hospitals.
- (2) Nutrition course for institutional cooks.
- (3) Nutrition inspection and consultation service to small general hospitals, municipal homes and hospitals, child caring institutions, summer camps, etc.
- (4) "Calling All Cooks" booklet distributed every two months to cooks in the above institutions.

VIII REHABILITATION

- (1) Provision of medical and vocational assessment.
- (2) Referral to Vocational Training services of Department of Education.
- (3) Referral to Job Placement Service of National Employment Service.
- (4) Provision of a continuous counselling service in the field.

Tourist Accommodation

in matters of sanitation in the above accommodation.

Slaughter Houses nuisances rodent control
Fish Plants food shops insect control

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(1) Tuberculin surveys for county homes and county hospitals.

(2) Nutrition course for institutional cooks.

(3) Small general hospitals, municipal homes and hospitals, child caring institutions, summer camps, etc.

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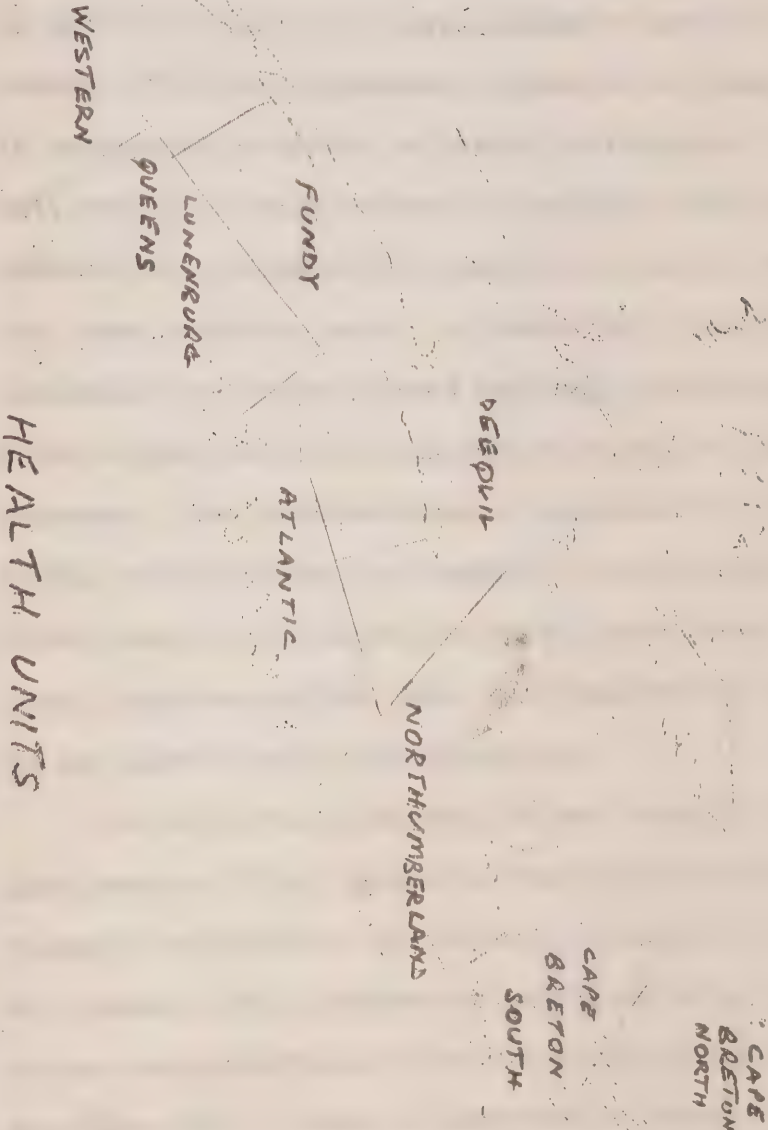
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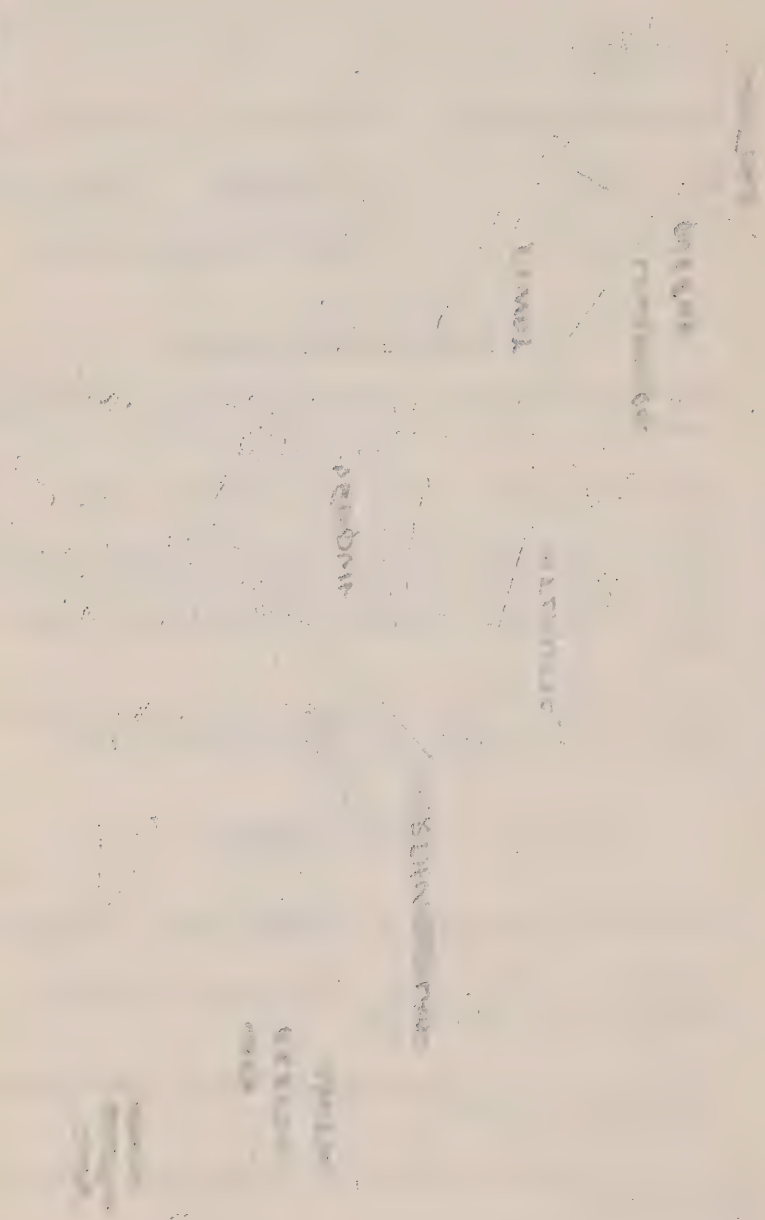
(3) Referral to Job Placement Service of National

(4) Provision of a continuous counselling service in the field.





NEW YORK





1 PROVINCIAL ASSISTANCE PROGRAMS IN WHICH THERE
2 IS A MEDICAL COMPONENT

3 For many years going back to 1930 the Department
4 paid Mother's Allowance to certain needy mothers who were
5 widowed and who had children under sixteen years of age.
6 In 1942 this legislation was amended to provide for the
7 payment of these allowances to women whose husbands were
8 in provincial sanatoria or mental institutions. In 1943
9 this provision was broadened to include women whose
10 husbands were permanently disabled to such an extent that
11 they were unable to work. On March 31st, 1960, 2,210
12 allowances were in pay under this legislation and 828 of
13 these allowances were being paid to wives of disabled
14 husbands. The Department has an agreement with the Nova
15 Scotia Medical Society in respect to this program and
16 Blind Person's Allowance and the Society through its
17 agent, Maritime Medical Care, provides medical benefits
18 to the beneficiaries and dependents.

19 The Mother's Allowances Act was repealed at the
20 last session of the Legislature and all of the provisions
21 formerly contained in the Mother's Allowances Act along
22 with certain other broadening provisions were included
23 in new Social Assistance legislation termed the Social
24 Assistance Act. There is therefore no Mother's Allowances
25 Act in Nova Scotia at the present time and all former
26 Mother's Allowances payments are being made now under the
27 Social Assistance Act.

28 The Federal Government enacted the Disabled Persons'
29 Act in 1954 and the Province of Nova Scotia enacted the
30 necessary legislation and has paid allowances to this

PROVINCIAL ASSISTANCE PROGRAMS IN WHICH THERE
IS A MEDICAL COMPONENT

For many years going back to 1930 the Department paid Mother's Allowance to certain needy mothers who were widowed and who had children under sixteen years of age. In 1942 this legislation was amended to provide for the payment of these allowances to women whose husbands were in provincial sanatoria or mental institutions. In 1943 this provision was broadened to include women whose husbands were permanently disabled to such an extent that they were unable to work. On March 31st, 1960, \$210 allowances were in pay under this legislation and 828 of these allowances were being paid to wives of disabled husbands. The Department has an agreement with the Nova Scotia Medical Society in respect to this program and Blind Person's Allowance and the Society through its agent, Maritime Medical Care, provides medical benefits to the beneficiaries and dependents.

The Mother's Allowances Act was repealed at the last session of the Legislature and all of the provisions formerly contained in the Mother's Allowances Act along with certain other broadening provisions were included in new Social Assistance legislation termed the Social Assistance Act. There is therefore no Mother's Allowances Act in Nova Scotia at the present time and all former Mother's Allowances payments are being made now under the Social Assistance Act.

The Federal Government enacted the Disabled Persons' Act in 1954 and the Province of Nova Scotia enacted the necessary legislation and has paid allowances to this



category since January 1955 at the maximum level permitted by the Federal Legislation. Disabled Person's Allowance is granted by the Province to persons who qualify under the conditions specified in the Disabled Person's Act and Regulations which is Chapter 55 of the Acts of Canada of 1954. This Act enables the Minister of National Health and Welfare to make agreements with the provinces. The Province may pay allowances not exceeding \$55.00 per month and collect fifty per cent of the costs from the Federal Government. The Federal Government will share only those payments made by a Province where the recipient is totally and permanently disabled as prescribed by the Federal Regulations. The Regulations in respect to disability are interpreted by a joint Medical Review Board. It should be emphasized that there have been changes in the definition of permanent and total disability as defined under this legislation in 1954 and there has been some broadening of the definition.

However, the definition has been such that a considerable number of applicants have been excluded on medical grounds under the Federal Regulations, although for all practical purposes the rehabilitation of such persons cannot be affected so that the individual might be able to support himself or his family. In order to provide for these cases ineligible under the Disabled Person's Act and yet very severely disabled and unable to support themselves, the Social Assistance Act was amended and the following provision made in it:

" 7(c) From a date to be fixed by the Governor in Council, Social Assistance may be granted to a person who has attained the age of eighteen years but who has not reached

category since January 1955 at the maximum level permitted
is granted by the Province to persons who qualify under
the conditions specified in the Disabled Person's Act
and Regulations which is Chapter 55 of the Acts of Canada
of 1954. This Act enables the Minister of National Health
and Welfare to make agreements with the provinces. The
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persons cannot be effected as that the individual might
be able to support himself or his family. In order to
provide for these cases ineligible under the Disabled
Person's Act and yet very severely disabled and unable
to support themselves, the Social Assistance Act was
amended and the following provision made in it:
"Y(c) From a date to be fixed by the Governor in Council
Social Assistance may be granted to a person who has
attained the age of eighteen years but who has not reached



1 the age of sixty-five who, by reason of permanent
2 disability, is unable to support himself and who is not
3 in receipt of an allowance under the Blind Person's
4 Allowance Act or the Disabled Person's Allowance Act or
5 Social Assistance under Clause (a) or (b)".

6 This means that the mother or father in a family
7 receiving assistance under what was the Mother's
8 Allowance Act will not be eligible for assistance under
9 this new Section.

10 These payments will be made effective July 1st, 1960
11 and applications are now being received under this
12 legislation.

13 It should be clearly understood that a person in
14 order to be eligible for Social Assistance under this new
15 Section of the Act must be severely disabled. It may be
16 noted that the definition of "disability" under this
17 Section of the Act is narrower in interpretation than
18 that used in Section 7 (a), or what was formerly the
19 Mother's Allowance Act. The word "permanently" used in
20 Section 7(c) above will be construed as meaning a
21 disability which is continuous for an indefinite period
22 of time or a disability in which a definite prognosis
23 cannot be made and which, therefore, is likely to continue
24 unabated for a long period of time.

25 Diseases such as tuberculosis, mental illness and
26 gastric ulcer will not qualify as permanent disabilities
27 while under active treatment or while the patient is
28 considered treatable with an expectation of whole or
29 partial recovery or rehabilitation. In general terms,
30 a person suffering from a treatable illness will not
qualify until maximum benefit has been obtained from the
treatment.

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section 7(c) above will be construed as meaning a

disability which is continuous for an indefinite period

of time or a disability in which a definite prognosis

cannot be made and which, therefore, is likely to continue

repeated for a long period of time.

Diseases such as tuberculosis, mental illness and

gastric ulcer will not qualify as permanent disabilities

while under active treatment or while the patient is

considered unstable with an expectation of whole or

partial recovery or rehabilitation. In general terms,

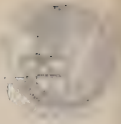
a person suffering from a treatable illness will not

qualify until maximum benefit has been obtained from the



1 The person must be totally disabled, that is to
2 say, the disability must be so sever and the residual
3 work capacity so limited that the individual is totally
4 unable to earn a livelihood. The maximum payable is
5 \$40.00 per month and the means test provides that the
6 maximum income shall be \$720.00 including assistance for
7 a single person and \$1,200.00 including assistance plus
8 \$180.00 for each dependent, for a married person.

9 The only other assistance program in the Department
10 of Welfare involving a medical component is the Blind
11 Person's Allowance, which is payable in much the same
12 manner as the Disabled Person's Allowance to needy persons
13 with a certain degree of blindness defined by a Federal
14 Regulation.



The person must be totally disabled, that is to say, the disability must be so severe and the residual work capacity so limited that the individual is totally unable to earn a livelihood. The maximum payable is \$40.00 per month and the means test provides that the maximum income shall be \$750.00 including assistance for a single person and \$1,200.00 including assistance plus \$180.00 for each dependent, for a married person.

The only other assistance program in the Department of Welfare involving a medical component is the Blind Person's Allowance, which is payable in much the same manner as the Disabled Person's Allowance to needy persons with a certain degree of blindness defined by a Federal



APPENDIX XVI

MEMBER ORGANIZATIONS OF THE NOVA SCOTIA REHABILITATION
COUNCIL

Nova Scotia Division or Section of:

Canadian Arthritis & Rheumatism Society

Canadian Association of Social Workers

Canadian Cancer Society

Canadian Foundation for Poliomyelitis &
Rehabilitation

Canadian Mental Health Association

Canadian National Institute for the Blind

Canadian Paraplegic Association

Canadian Red Cross Society

and

Children's Hospital

Dalhousie Public Health Clinic

Department of Education

Department of Public Health

Department of Labour

Department of Public Welfare

Department of Veterans' Affairs

Halifax County Anti-T.B. League

Halifax-Dartmouth Labour Council

Maritime School of Social Work

Minas Cerebral Palsy Association

Nova Scotia Association for Help of Retarded
Children

Nova Scotia Society for the Care of Crippled
Children

Nova Scotia Tuberculosis Association

Unemployment Insurance Commission

Victorian Order of Nurses

APPENDIX XVI

COPIES

Novo Scotia Division or Section of:

Canadian Arthritis & Rheumatism Society

Canadian Association of Social Workers

Canadian Foundation for Polio Research &
Recovery

Canadian National Institute for the Blind

Canadian Paraplegic Association

Canadian Red Cross Society

and

Delaware Public Health Clinic

Department of Education

Department of Public Health

Department of Labour

Department of Public Welfare

Department of Veterans' Affairs

Halifax County Anti-T.B. League

Halifax-Parliament Labour Council

Maritime School of Social Work

Nova Scotia Paraplegic Association

Novo Scotia Association for Help of Retarded
Children

Novo Scotia Society for the Care of Crippled
Children

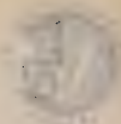
Novo Scotia Tuberculosis Association



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Welfare Council of Halifax

Workmen's Compensation Board.



Welsh Council of Halifax

Welsh Council of Halifax

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TABLE 1.

NUMBER OF DOCTORS ON RESIDENT LIST IN NOVA SCOTIA
REGISTER*

	<u>June 30, 1961</u>	<u>Medical School of Graduation</u>		
			<u>Other</u>	
		<u>Dal.</u>	<u>Candn.</u>	<u>Other</u>
Retired	33	24	3	6
Active General Practice	385	290	33	62
Specialty Practice	212	137	26	49
Post-Graduate Training	56	39	3	14
Administrative - salaries et al	66	39	7	20
Females not in practice	18	5	1	12
Military Service	37	4	15	18
Moved from Nova Scotia	2	2	0	0
Total	<u>809</u>	<u>540</u>	<u>88</u>	<u>181</u>

New Registrants resident in Nova Scotia included.

	<u>June 30th, 1959</u>	<u>June 30, 1960</u>
Retired	65	40
Active General Practice	317	334
Specialty Practice	190	182
Post-Graduate Training	43	37
Administrative - salaries et all	72	8**
Military Service	39	33
Died during the year	9	3
Moved from Nova Scotia		10
Total	<u>735</u>	<u>719</u>

** Includes wives not active (18). New Registrants for these years not included.

* Source: Registrar, Provincial Medical Board.

NUMBER OF DOCTORS ON RESIDENT LIST IN NOVA SCOTIA

Graduation

Retired	33	24	3	6
Active General Practice	385	290	33	62
Specialty Practice	212	137	26	49
Post-Graduate Training	56	39	3	14
Administrative - salaries et al	66	39	7	20
Females not in practice	13	5	1	12
Military Service	37	4	15	13
Moved from Nova Scotia	2	2	0	0
Total	602	540	88	181

New Registrants resident in Nova Scotia included.

June 30th, 1959

Retired	62		
Active General Practice	317		
Specialty Practice	137		
Post-Graduate Training	43		37
Administrative - salaries et al	72		8**
Military Service	39		22
Moved from Nova Scotia			10
Total	732		142

** Includes wives not active (18). New Registrants for these years not included.

* Source: Registrar, Provincial Medical Board.

TABLE 2.

PHYSICIANS IN SPECIALTY PRACTICE IN N.S. JUNE 30, 1961*

Specialty	NO.	Medical School of Graduation		
		<u>Da1.</u>	<u>Other Candn.</u>	<u>Other</u>
Internal Medicine	24	20	3	1
Dermatology	3	1	0	2
Psychiatry	22	12	1	9
E E N T	29	20	4	5
Anaesthesia	16	10	2	4
Obstetrics & Gynaecology	11	8	1	2
Pathology & Bacteriology	13	1	1	11
Radiology	21	10	4	7
Radiotherapy	3	0	1	2
Paediatrics	12	9	1	2
Neuro-Surgery	2	1	1	0
Physical Medicine	2	2	0	0
General Surgery	43	35	6	2
Orthopaedic Surgery	6	3	1	2
Urology	5	5	0	0
Total	<u>212</u>	<u>137</u>	<u>26</u>	<u>49</u>

* Source: Registrar, Provincial Medical Board.

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Specialty	No.	1941	1942	1943
Internal Medicine	24	20	3	1
Obstetrics & Gynaecology	11	8	1	2
Pathology & Bacteriology	13	1	1	11
Radiology	21	10	4	7
Paediatrics	12	9	1	2
Neuro-Surgery	2	1	1	0
Physical Medicine	2	2	0	0
General Surgery	43	35	6	2
Orthopaedic Surgery	6	3	1	2
Urology	2	2	0	0
	131	131	27	40

Medical School of Graduation

REGISTRATION OF MEDICAL OFFICERS IN N.E. JUNE 30, 1961*



1 MR. HALL: There are a few questions I
2 would like to address to Dr. Giffin. On page 20 of the
3 brief, paragraph 78, you state that under the medical
4 health plan -- the Maritime Medical Care, I think it is --
5 that subscribers' rights and privileges are doubly super-
6 vised by non-medical representation on Boards of Directors
7 of such plans: can you tell me how these non-medical
8 representatives get on the Board?

9 DR. GIFFIN: In the case of Maritime Medical
10 Care, they are appointed by the Board of Directors. They
11 are five in number presently. There are, in addition,
12 12 medical members on the Board.

13 MR. HALL: Does that mean there are a total
14 of 17 on the Board?

15 DR. GIFFIN: 17 on the Board.

16 MR. HALL: And the non-medical members are
17 not directly responsible to the subscribers; they are
18 appointed by the other members of the Board?

19 DR. GIFFIN: That is correct, but they are
20 chosen, of course, from the laity at large.

21 MR. HALL: But not by the subscribers them-
22 selves?

23 DR. GIFFIN: That is correct, they are not
24 chosen by the subscribers themselves.

25 MR. HALL: Do they have an equal vote with
26 other members of the Board?

27 DR. GIFFIN: They do have an equal vote
28 with other members of the Board.

29 MR. HALL: And in the case of Maritime
30 Medical Care are decisions made by a majority of the Board?

1d like to address to Dr. Giffin. On page 20 of the
 1st, paragraph 78, you state that under the medical
 health plan -- the Maritime Medical Care, I think it is --
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 DR. GIFFIN: They do have an equal vote
 with other members of the Board.
 MR. HALL: And in the case of Maritime
 Medical Care are decisions made by a majority of the Board?



1 DR. GIFFIN: That is correct, majority
2 decisions are made.

3 MR. HALL: And that majority could always
4 be held by the medical representation on the Board as it
5 is presently constituted?

6 DR. GIFFIN: That is a correct statement.
7 However, the import of the statement might have different
8 interpretations, Mr. Chairman.

9 MR. HALL: Well, we are here to get informa-
10 tion, so anything you can add -- the Commission wants all
11 the assistance it can get.

12 DR. GIFFIN: We find in practice that the
13 contribution of the lay members is an exceedingly great
14 one. We benefit from their financial judgment and, as
15 you can imagine, the management of considerable sums of
16 money is one of our duties, and we find them most helpful
17 even in matters that may be considered to be purely profes-
18 sional. We take their advice particularly when it has a
19 bearing upon the level of benefits for interpretation of
20 contract.

21 MR. HALL: Will you tell us how long the
22 Trans-Canada Medical Plans have been in existence?

23 DR. GIFFIN: Mr. Chairman, with your permis-
24 sion, could I refer that to Mr. Brannan, our General
25 Manager?

26 THE CHAIRMAN: Indeed.

27 MR. BRANNAN: I believe, Mr. Chairman, since
28 approximately 1950 -- and I don't know the exact date --
29 but about that time.

30 MR. HALL: And are all plans of the same

MR. HALL: And are all plans of the same

but about that time.

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MR. HALL: And that majority could always

positions are made.



1 type as Maritime Medical Care in Canada members of Trans-
2 Canada Medical Plans?

3 MR. BRANNAN: Yes, all plans either approved
4 or sponsored by the medical profession in the Province in
5 which they are operating are members of Trans-Canada
6 Medical Plans.

7 MR. HALL: At page 20 in paragraph 83
8 reference is made to the type of service provided by
9 commercial carriers, and you state that on the whole their
10 plans are marked by indemnity features, certain exclusions,
11 non-coverage of pre-existing diseases and provisions for
12 termination of contracts: isn't it correct that those
13 grants apply to the Maritime Medical Care contracts also,
14 or to a different degree perhaps?

15 DR. GIFFIN: It is correct that Maritime
16 Medical Care has several types of contracts, and they
17 are in the appendix, but our comprehensive plan does not
18 have any exclusions provided it is taken over as a group.
19 The other feature of Maritime Medical plans is that the
20 contract is not terminated on the employee leaving his
21 employer if he chooses to carry it on as an individual.
22 Perhaps Mr. Brannan could spell this out in a little more
23 detail.

24 MR. HALL: On the individual plan, Mr.
25 Brannan, there is provision for cancellation?

26 MR. BRANNAN: Yes, on the individual plan
27 there is provision for cancellation. This is not exer-
28 cised. It is in there for the obvious reason that on the
29 individual plan there is a free election of a fairly high
30 level of benefits. The need for an exclusion for

MR. BRANNAN: Yes, all plans either approved

or sponsored by the medical profession in the Province in which they are operating are members of Trans-Canada Medical Plans.

MR. HALL: At page 20 in paragraph 83 reference is made to the type of service provided by commercial carriers, and you state what on the whole their plans are marked by indemnity features, certain exclusions, non-coverage of pre-existing diseases and provisions for termination of contracts: isn't it correct that those plans apply to the Maritime Medical Care contracts also, or to a different degree perhaps?

MR. BRANNAN: The Maritime Medical Care has several types of contracts, and they are in the appendix, but our comprehensive plan does not have any exclusions provided it is taken over as a group. The other feature of Maritime Medical plans is that the contract is not terminated on the employee leaving his employer if he chooses to carry it on as an individual. Perhaps Mr. Brannan could spell this out in a little more detail.

MR. HALL: On the individual plan, Mr. Brannan, there is provision for cancellation?

MR. BRANNAN: Yes, on the individual plan there is provision for cancellation. This is not ex-

cluded. It is in there for the obvious reason that on the

level of benefits. The need for an exclusion for



1 pre-existing conditions which exists on an individual
2 plan is obvious in that a person could elect by paying
3 one month's premium to join a plan to take care of some
4 immediate need, such as surgery, and leave the plan having
5 received the service expecting the remaining members to
6 absorb the cost. The reference to indemnity in the brief
7 is a means of comparing the service approach that the
8 doctors-sponsored program in Nova Scotia uses, namely, we
9 do not state the fee for the service. We adopt the
10 schedule of fees of the Medical Society of Nova Scotia
11 and our reimbursement is on that basis.

12 MR. HALL: But you set a ceiling on the
13 amount you will pay under the contract under different
14 circumstances. I think in one place you say a limit of
15 \$500.

16 MR. BRANNAN: That is on the individual
17 plan. There is a dollar limit on the individual plan,
18 but not on the group program.

19 MR. HALL: If the medical bill exceeds \$500,
20 then you are becoming just an indemnifying agent up to
21 the extent of \$500?

22 MR. BRANNAN: To the extent this is for
23 one service in any one year.

24 MR. HALL: Yes.

25 MR. BRANNAN: The \$500 limit only applies
26 in the case of one particular condition or in any one
27 year. To that extent, yes. To some extent it could be
28 argued that where a diagnostic limit applies in a service
29 plan that the limit there is applied diagnostically and
30 is also indemnity.



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MR. HALL: But you set a ceiling on the amount you will pay under the contract under different circumstances. I think in one place you say a limit of \$500.

MR. BRAUNMAN: That is on the individual plan. There is a dollar limit on the individual plan, but not on the group program.

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plan that the limit there is applied diagnostically and is also indemnity.



1 MR. HALL: But apart from the limitation
2 regarding pre-existing conditions, doesn't your individual
3 plan also contain a clause which gives you the right to
4 terminate it at any time?

5 MR. BRANNAN: Yes.

6 MR. HALL: Have you ever invoked that clause
7 for any reason other than non-payment of premiums?

8 MR. BRANNAN: To my knowledge they have
9 never had to use it. It is there primarily in the event
10 of falsification of original documentation by the appli-
11 cant when he applies for membership, though we have had
12 none, to my knowledge; we have never had to use it.

13 MR. HALL: It just occurred to me that was
14 rather a broad power to cover that situation when it could
15 be spelled out specifically. Has your organization given
16 any consideration to a plan which would cover pre-existing
17 diseases and conditions?

18 MR. BRANNAN: Mr. Chairman, we are in a way
19 experimenting with that now. Actually, in our seniors'
20 health plan we have taken a calculated risk in permitting
21 persons aged 60 and over to receive in-hospital medical
22 care primarily without a specific exclusion for pre-exis-
23 ting conditions. The only qualification we have made is
24 that if they are undergoing treatment at the time the
25 contract takes effect the coverage won't begin until the
26 day following their discharge, or something like that.
27 But this is our first experiment in providing a contract
28 on an individual basis as opposed to group coverage without
29 exclusion for pre-existing conditions.

30 MR. HALL: Has it been in operation long



1 regarding pre-existing conditions, doesn't your individual
 2 plan also contain a clause which gives you the right to
 3 terminate it at any time?

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 23 day following their discharge, or something like that.

24 But this is our latest experiment in providing a contract
 25 on an individual basis as opposed to group coverage without

26 MR. HALL: Has it been in operation long



1 enough for you to give an opinion as to the effect it is
2 going to have on cost of providing medical care?

3 MR. BRANNAN: It is a little early to say
4 because we could not list them all -- there are a few
5 short waiting periods in them of six months, and we have
6 just had our first anniversary of the program, and
7 although it has carried itself financially so far on the
8 rates we are charging we would prefer to wait until there
9 has been a year's experience and most of the members have
10 completed their waiting years to see if there are any
11 unforeseen expenses on them.

12 MR. HALL: How do the rates you are charging
13 compare with the rates charged on the ordinary individual
14 plan?

15 MR. BRANNAN: The individual plan -- this
16 includes home and office calls, whereas the seniors'
17 health plan does not. The individual plan quarterly rates
18 are \$9.20 for a single subscriber; \$20.60 for a couple;
19 and \$26.40 for families -- the quarterly premium. The
20 seniors pay their premiums on a monthly basis because
21 most of them are pensioners: \$1.85 single; \$3.70 a couple;
22 and \$4.95 a family. I think the rate that perhaps would
23 come closer to comparing coverages is our health security
24 plan, and this is primarily an in-hospital program, and
25 it is in the appendix. We charge a single person under
26 health security \$1.20 as opposed to the single we charge
27 at \$1.85. The \$2.60 rate on health security, \$3.70 to
28 the seniors. \$3.60 a month for the family as opposed to
29 \$4.95. From the figures I have seen over the course of
30 the years I think the cost of a person over the age of 65



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29 \$4.95. From the figures I have seen over the course of
30 the years I think the cost of a person over the age of 65



1 is approximately $2\frac{1}{2}$ times as much as those under 65, and
2 this is why it was our Board's decision to start on in-
3 hospital benefit level first and see how far we can go
4 before we went into home and office care.

5 MR. HALL: On page 21, paragraphs 87 to 90,
6 reference is made to emergency hospital by physicians on
7 salary by one large industrial employer: have you any
8 evidence that would indicate that the quality of care
9 received by an injured employee under that situation is
10 anything inferior to what he would receive from a doctor
11 of his own choice?

12 DR. McDONALD: Mr. Chairman, I believe this
13 particular case does not refer to the capitation cases.
14 This is more the case of an employer's field company, and
15 the quality of care is as good given by the company itself
16 as their own physician would give. It would appear no
17 better, in my opinion, and no worse.

18 DR. GIFFIN: The only point we make is that
19 under this system they are denied the choice of their own
20 family physician, but we don't say the quality of care is
21 any worse.

22 MR. HALL: Would you say under the system
23 referred to in paragraphs 87 to 90 that the care is
24 provided at a substantially lower cost?

25 DR. GIFFIN: I have no figures to substantiate
26 that. It would have to be compared, I would think, by the
27 cost of care -- what comes under the Workmen's Compensation
28 Board.

29 DR. McDONALD: We have no figures on that.
30 The understanding is that, of course, the compensation



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 2 this is why it was our Board's decision to start on in-
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The understanding is that, of course, the compensation



1 rate paid by the company to the Province of Nova Scotia
2 Workmen's Compensation Board is less. We have never had
3 those figures, and I don't know if they are available.

4 MR. HALL: On page 23, paragraph 93,
5 reference is made to the multiplicity of voluntary agen-
6 cies. Has your Society any suggestions as to methods
7 which may be employed to correlate the efforts of these
8 voluntary agencies?

9 DR. GIFFIN: We do cite as an example of a
10 good trend the gathering together of the agencies under
11 the Rehabilitation Council in Halifax and that probably,
12 we think, should be extended.

13 MR. HALL: Do you think there should be some
14 public authority in control or direction of the agencies?

15 DR. GIFFIN: We do feel that their programs
16 should be reviewed by an authority, and we would suggest
17 that perhaps the Provincial Departments of Health would
18 have the machinery to undertake this.

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have the machinery to undertake this.



1 MR. HALL: How far should that extend?

2 Approval of projects, limitation of expenditures, things
3 of that nature?

4 DR. GIFFIN: I would think it would take
5 in all pertinent points. One would be program; second
6 would be the efficient use of monies.

7 MR. HALL: On page 42, paragraph 154, you
8 refer to a system provided by participation of a Govern-
9 ment and the medical profession. What do you mean by
10 participation by the medical profession?

11 DR. GIFFIN: Participation in the sense
12 that the medical profession would provide the services,
13 and we also would perceive that there would be details
14 which would have to be worked out by both the Department
15 and the profession to bring that type of coverage into
16 being.

17 MR. HALL: On page 55, paragraph 186, you
18 make reference to the increased cost caused by the greater
19 utilization of services and longer hospital stay under the
20 circumstances referred to in the paragraph. Could this
21 be partly explained by a backlog of unmet needs at the
22 time of the conception of the program?

23 DR. GIFFIN: I think that is accurate.
24 Certainly some of the increased costs are going to be due
25 to the fact of perhaps longer and necessary stay in hospi-
26 tal as has been advised, whereas before the scheme came
27 into effect a patient might wish to leave a hospital
28 sooner than his doctor in attendance may advise. So some
29 of this cost is legitimate and does represent a meeting
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1 MR. HALL: Would it be correct to say that
2 the doctor himself plays the most important role in
3 determining the utilization by the patient of the facili-
4 ties?

5 DR. GIFFIN: Yes, that is correct. Particu-
6 larly in Nova Scotia it is the doctor who orders the
7 patient to hospital and it is the doctor who discharges
8 the patient. So it is based really on his integrity and
9 his judgment.

10 MR. HALL: In view of that, can the Society
11 make any recommendations to avoid the situation you refer
12 to there?

13 DR. GIFFIN: We have made recommendations.
14 We think if we had beds for the chronically ill and could
15 remove them from the active treatment hospitals, then
16 there would certainly be more beds for acute conditions
17 and their longer stay would be in relationship to its
18 proper category and perhaps at a lower figure, because we
19 do not think that it would cost as much to operate a
20 convalescing chronic bed than it would be an active bed in
21 a hospital with diagnostic facilities.

22 MR. HALL: Just a few more questions, Doctor,
23 referring to page 63, paragraph number 10. If I understand
24 that paragraph, you are recommending that the premium for
25 an indigent to participate in Maritime Medical Care be
26 paid by some outside agency, Government agency or ---

27 DR. GIFFIN: Government agency.

28 MR. HALL: Are you also recommending that
29 those who can't afford to pay the full premium and who
30 cannot be classed as indigents, that their premium be



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18. convalescing chronic bed than it would be an active bed in

19. a hospital with diagnostic facilities.

20. MR. HALL: Just a few more questions, Doctor.

21. Referring to page 63, paragraph number 10. If I understand

22. you correctly, you are recommending that the Government

23. should by some outside agency, Government agency or

24. (faint text)

25. MR. HALL: Are you also recommending that

26. those who can't afford to pay the full premium and who

27. cannot be placed as indigents, that they should be



1 subsidized?

2 DR. GIFFIN: That is correct. It is sub-
3 dized at present, sometimes wholly, where it is in the
4 proper area for Government to subsidize.

5 MR. HALL: Have you given any consideration,
6 then, as to whether the Government should have any say or
7 control on the amount of premium under the plan if that is
8 the case?

9 DR. GIFFIN: That again is a detailed nego-
10 tiation, Mr. Chairman.

11 MR. HALL: What do you think yourself of
12 that situation? Do you think there should be participation
13 by the Government in establishing the rate of premium?

14 DR. GIFFIN: Establishing the premium, did
15 I understand it?

16 MR. HALL: Rate of premium, cost of partici-
17 pating in the scheme.

18 DR. GIFFIN: It would have to be done in
19 negotiation between Government and the insuring agency,
20 and we, of course, would hope it would be Maritime Medical
21 Care.

22 MR. HALL: What would happen if you didn't
23 agree on the rate of premium?

24 DR. GIFFIN: I would think, Mr. Chairman,
25 that some agreement could be reached, at least for a
26 period, and then you would base re-negotiation on the
27 actuarial result. We have already had inquiries from a
28 Federal department on that basis. This is the approach
29 that M.M.C. has taken.

30 MR. HALL: I think that covers that for now,



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period, and then you would have no negotiation on the

actual result. We have already had subsidies from a

Federal department on that basis. This is the approach

that I think that we should take.

MR. HALL: I think that covers that for now.



1 thank you, Doctor.

2 I would like to address one more question.

3 On page 111, the section dealing with medical care, you
4 set out the percentage paid out by way of benefits in the
5 years 1956 to 1960 inclusive. Was all of the difference
6 used in administration or was there reserve in these
7 years?

8 MR. BRANNAN: Mr. Chairman, in some of the
9 earlier years there was nothing set aside. In 1959 and
10 1960 we began a program of setting by systematically
11 reserves and our goal is 2% of the premium per year. We
12 are now at the point where we try to set aside reserves.
13 But our method of reimbursing has been on the basis of
14 pro-ration; where there are insufficient dollars available
15 from premiums, then the participating physicians in the
16 plan take less.

17 MR. HALL: How many take part, in how many
18 years?

19 DR. GIFFIN: All the years, Mr. Chairman.
20 It is 85%.

21 MR. HALL: Was the rate of premium increased
22 to make provision for reserve or was it cut down?

23 MR. BRANNAN: I understand on July 1st,
24 1959, there was an adjustment in premium. This wasn't
25 primarily to cover a reserve factor; it was also an adjust-
26 ment in schedule of fees in which we were reimbursing our
27 participating physicians. It was approximately at that
28 time that the Board of Directors felt that in order to
29 stabilize pro-ration for the benefit of participating
30 physicians we should begin to set aside a 2% stabilization



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31 MR. HALL: How many have gone, in how many
 32 years?

33 MR. GLASS: All the years, Mr. Chairman.
 34 It is 52%.

35 MR. HALL: Was the rate of premium increase
 36 to make provision for reserve or was it cut down?
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 38 1959, there was an adjustment in premium. This wasn't
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 42 time that the Board of Directors felt that in order to
 43 stabilize pre-tation for the benefit of participating
 44 physicians we should begin to set aside a 2% stabilization



1 reserve, and this has been done since that time.

2 MR. HALL: Apart from revision such as you
3 have mentioned, I take it the rate of premium hasn't
4 fluctuated?

5 MR. BRANNAN: It hasn't fluctuated materially,
6 and it hasn't changed since 1959.

7 DR. JOBIN: Mr. Chairman, I would like to
8 congratulate the Medical Society of Nova Scotia for their
9 very excellent brief. On the point of relieving the
10 present and future needs for doctors and perhaps to subsi-
11 dize the medical students, in your opinion do you think
12 that these subsidies should cover the tuition fees and
13 the maintenance or the fees only? How much per person?
14 For average students or for the top-ranking ones? For
15 all the duration of the course or for the two or three
16 last years? Do you foresee a kind of reimbursing for
17 this subsidy?

18 DR. GIFFIN: Mr. Chairman, in talking about
19 this matter, subsidization, in our Committee we were not
20 firmly convinced that it should be paid to the students;
21 we saw that it might be paid to the University to reduce
22 the students' fees. Now, another subsidy, which we didn't
23 go into too deeply, was whether or not it should be in the
24 nature of a loan or repayable. Was there any other aspect?

25 DR. JOBIN: No. But I think, Mr. Chairman,
26 that members of the Medical Society of Nova Scotia should
27 study that question.

28 THE CHAIRMAN: That may be. It is not up to
29 us to tell anybody what they should do.

30 DR. GIFFIN: Mr. Chairman, we would be happy

1 nervous, and this has been done since that time.

2 MR. HALL: Apart from revision such as you

3 have mentioned, I am in the same position.

4 MR. BRANNAN: It hasn't illustrated material

5 and it hasn't changed since 1955.

6 DR. JOBIN: Mr. Chairman, I would like to

7 mention the fact that the University of Toronto

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9 present and future needs for doctors and perhaps to what

10 give the medical students, in your opinion do you think

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24 that members of the Medical Society of Nova Scotia should

25 study that question.

26 THE CHAIRMAN: That may be. It is not up to

27 us to tell anybody what they should do.

28 DR. GIBLIN: Mr. Chairman, we would be happy

29 to study that question.



1 to make a note of that, and if we can get figures on it
2 we would be very happy to submit it to the Commission.

3 DR. JOBIN: Yes, because there is a very
4 great lack of doctors, and in future it will get worse,
5 and if you want to attract students you have to subsidize
6 the candidate, and I think it would be helpful to the
7 Commission to study that. I have only two more points.
8 On pages 89, 90 and 91 you refer to a universally available
9 voluntary medical service insurance. Would you explain to
10 the members of the Commission why you prefer a non-profit
11 plan by private enterprise, of course with the help of
12 Government for the indigent, rather than for a Government
13 system?

14 DR. GIFFIN: I think that we have made
15 comment upon that, Mr. Chairman, on page 63, paragraph 210.
16 I think that gives our views upon that, Mr. Chairman, in
17 the last two sentences, where we are talking about the
18 "Further participation to provide coverage for the indigent
19 of the Province and a graded scale of contributions for
20 those of low income, would present no true problem other
21 than to find the financial resources. Although this would
22 be a substantial figure, it would be proportionately
23 small in relation to the total cost of health care currently
24 provided in Nova Scotia". In other words, we have 2½
25 million dollars, whereas in the year 1960 the total cost
26 of health services in Nova Scotia we find was of the order
27 of 63 million dollars. That is what we mean by saying it
28 would be proportionately small. "However, it would be
29 substantial enough to underline the wisdom of making the
30 availability of medical services insurance voluntary so



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15 comment upon that, Mr. Chairman, on page 63, paragraph 210.
16 I think that gives our views upon that, Mr. Chairman, in
17 the last two sentences, where we are talking about the
18 "Further participation to provide coverage for the indigent
19 of the Province and a graded scale of contributions for
20 those of low income, would present no true problem other
21
22 be a substantial figure, it would be proportionately
23 small in relation to the total cost of health care currently
24 provided in Nova Scotia". In other words, we have 2 1/2
25 million dollars, whereas in the year 1960 the total cost
26 of health services in Nova Scotia we find was of the order
27 of 63 million dollars. That is what we mean by saying it
28 would be proportionately small. However, it would be



1 that the self-supporting citizens of the Province who
2 have the financial ability to pay for their physicians'
3 services may either elect to do so directly or through
4 the prepaid plan".

5 Now, that is our view on that, Mr. Chairman.

6 DR. JOBIN: Thank you. Now the last
7 question. To relieve the weight of recruiting physicians,
8 how much do you count on immigration?

9 DR. GIFFIN: I think the answer to that,
10 Mr. Chairman, would be more properly found in the medical
11 manpower study from the Canadian Medical Association, and
12 if I recall the preliminary discussions on that, it not
13 only told the figures of the reliance upon these physicians
14 but it also indicated a trend. Perhaps Dr. Kelly, who is
15 here as an advisor, could answer that question.

16 DR. KELLY: If I may attempt to answer that
17 question, Mr. Chairman. The experience in this country,
18 speaking of Canada as a whole, is that we have had an
19 average immigration of physicians from outside of Canada
20 of 420 per year for the last six years. I believe Dr.
21 Jobin phrased his question asking as to how much we should
22 rely on this. Personally I don't think we should rely on
23 it, because I don't think we can count on that number
24 continuing indefinitely, and I can think of circumstances
25 which would dry up that source of additional manpower
26 very quickly. That is the figure from a national basis,
27 and in these projections of ours to 1980 we have adopted
28 the more conservative figure from immigration of 300 per
29 year. In this Province the actual registration of non-
30 Canadian trained physicians during the 11-year period 1950



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30 Canadian trained physicians during the 11-year period 1950



1 to 1960 inclusive was a total of 319 of non-Canadian
2 persons registered. They did, of course, not all stay in
3 this Province; they scattered themselves very quickly
4 after their initial registration. But the annual intake
5 of foreign physicians has, during that 11-year period in
6 Nova Scotia, varied from a low of 16 in the lowest year
7 to a high of 64 in the highest year. There is a consi-
8 derable variation, and this is, you are reminded, one of
9 the Provinces that reciprocates with the General Medical
10 Council, and it is very simple for a physician from the
11 United Kingdom to register in Nova Scotia without taking
12 any preliminary examinations. I don't know how much we
13 should rely on this additional source of talent to the
14 medical profession. We have relied on it to a very marked
15 degree in the past. In my view it would be very unwise
16 to count on it indefinitely.

17 DR. JOBIN: Thank you very much.

18 THE CHAIRMAN: Ladies and gentlemen, it is
19 now going on quarter-to-five. We will adjourn until 9.30
20 tomorrow morning.

21
22 --- Whereupon the hearing adjourned until 9.30 a.m.,

23 Tuesday, October 31st, 1961.
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